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S. HRG. 99-276

THE INDIAN HEALTH PROMOTION AND DISEASE PREVENTION ACT OF 1985

HEARING

BEFORE THE

SELECT COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

NINETY-NINTH CONGRESS

FIRST SESSION

ON

S. 400

TO PROVIDE HEALTH PROMOTION AND DISEASE PREVENTION SERVICES TO INDIANS

JUNE 1, 1985
GALLUP, NM

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THE INDIAN HEALTH PROMOTION AND DISEASE PREVENTION ACT OF 1985

JUNE 1, 1985

U.S. SENATE,
SELECT COMMITTEE ON INDIAN AFFAIRS,
Gallup, NM.

The committee met, pursuant to notice, at 10 a.m., in the Kennedy School auditorium, Gallup, NM, Senator Dennis DeConcini (acting chairman) presiding.

Present: Senator Dennis DeConcini, Arizona; Senator Jeff Bingaman, New Mexico; and Representative Richardson, New Mexico.

Senator DECONCINI. Good morning, ladies and gentlemen. I am Senator Dennis DeConcini, State of Arizona, and I am very pleased to be here on behalf of the Select Committee on Indian Affairs, of which I am a member.

I want to welcome you all to the Senate Select Committee on Indian Affairs hearings today. We're here with the distinguished Senator from New Mexico, Senator Bingaman, and the most distinguished Representative, Bill Richardson, to receive testimony and comments on S. 400, the Indian Health Promotion and Disease Prevention Act of 1985.

I would like the record to show that we acknowledge and thank the chairman of the Senate Select Committee on Indian Affairs, Mark Andrews, and the ranking member, John Melcher, who has authorized these hearings.

We will hear from the Indian tribes and pueblos, Indian Health Service, Bureau of Indian Affairs, the States of New Mexico and Arizona. A number of representatives from community-based health programs will also be sharing their views with us.

Senator Bingaman, Representative Richardson, and I welcome the participation of everyone at this hearing.

Health promotion and disease prevention activities are critical to improving the health status of Native Americans. In a decade when there is a heightened concern about the increasing costs of primary health care, we must make sure that the health care system which the Native American community relies on addresses preventive health needs.

Senator Bingaman's introduction of this bill is timely, and I commend him for his leadership in the area. While S. 277, the Indian Health Care Improvement Act reauthorization, does speak in part to health promotion and disease prevention, the bill which we have before us today goes further in a number of very important respects. I share Senator Bingaman and Representative Richardson's concern that we take a comprehensive approach in addressing this aspect of Indian health care.

[The text of S. 400 follows:]

II

99TH CONGRESS
1ST SESSION

S. 400

To provide health promotion and disease prevention services to Indians.

IN THE SENATE OF THE UNITED STATES

FEBRAURY 6 (legislative day, JANUARY 21), 1985

Mr. BINGAMAN introduced the following bill; which was read twice and referred to the Select Committee on Indian Affairs

---

A BILL

To provide health promotion and disease prevention services to Indians.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Indian Health Promotion and Disease Prevention Act of 1985".

SEC. 2. The Congress finds that—

(1) health promotion and disease prevention activities will—

(A) improve the health and well being of Indians, and

(B) reduce the medical expenses of Indians,

(2) health promotion and disease prevention activities should be undertaken by the coordinated efforts of Federal, State, local, and tribal governments, and

(3) in addition to the provision of primary health care, the Indian Health Service should provide health promotion and disease prevention services to Indians.

DEFINITIONS

SEC. 3. Section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603) is amended by adding at the end thereof the following new subsections:

"(l) 'Health promotion' includes—

"(1) cessation of tobacco smoking,

"(2) reduction in the misuse of alcohol and drugs,

"(3) improvement of nutrition,

"(4) improvement in physical fitness, and

"(5) control of stress.

"(m) 'Disease prevention' includes—

"(1) immunizations,

"(2) control of high blood pressure,

"(3) control of sexually transmittable diseases,

"(4) family planning,

"(5) pregnancy and infant care,

"(6) control of toxic agents,

"(7) occupational safety and health,

"(8) control of accidental injuries,

"(9) fluoridation of water, and

"(10) control of infectious agents.".

HEALTH PROMOTION AND DISEASE PREVENTION PROGRAMS

SEC. 4. Title II of the Indian Health Care Improvement Act (25 U.S.C. 1621, et seq.) is amended by adding at the end thereof the following new sections:

"HEALTH PROMOTION AND DISEASE PREVENTION SERVICES

"SEC. 202. The Secretary, acting through the Service, shall provide health promotion and disease prevention services to Indians.

"COORDINATION OF ACTIVITIES; HEALTH PROMOTION AND DISEASE PREVENTION PLANS

"SEC. 203. (a) The Service shall coordinate all activities undertaken by the Department of Health and Human Services which involve, or relate to—

"(1) health promotion, or

"(2) disease prevention,

with respect to Indians.

"(b)(1) The Secretary, acting through the Service, shall conduct a study of—

"(A) the health promotion and disease prevention needs of Indians and the degree of each of such needs,

"(B) the health promotion and disease prevention activities which would best meet such needs, "(C) the resources which would be required to enable the Service to undertake the health promotion and disease prevention activities necessary to meet such needs,

"(D) the resources currently available to the Service which could be used to undertake such activities.

"(2) The Secretary, acting through the Service, shall—

"(A) develop a comprehensive plan for provision by the Service of health promotion and disease prevention services to Indians during the 3-year period beginning on the date of enactment of the Indian Health Promotion and Disease Prevention Act of 1985, and

"(B) develop a comprehensive plan for the provision of such services during the 10-year period beginning on the date of enactment of such Act.

Such plans shall specify a timetable for the provision of health promotion and disease prevention services by the Service.

"(3) Under regulations, the Secretary shall require that each Indian tribe include within any tribal health plan that such tribe is required to submit to the Secretary a comprehensive short-term plan and a long-term plan developed by such tribe for health promotion and disease prevention among members of such tribe.

"(4) The Secretary shall submit to the Congress by no later than the date that is 1-year after the date of enactment of the Indian Health Promotion and Disease Prevention Act of 1985 a report on the study conducted under paragraph (1). Such report shall include—

"(A) the plans which the Secretary is required to develop under paragraph (2),

"(B) a summary of any tribal plans described in paragraph (3) which have been submitted to the Secretary,

"(C) a description of health promotion and disease prevention activities being conducted by the Service, and

"(D) any recommendations for legislation that the Secretary determines to be necessary to enable the Service to provide the health promotion and disease prevention services that are necessary to meet the needs of Indians.

"(c) The Service shall employ additional personnel to fill at least 4 full-time equivalent positions which shall be used to carry out the duties of the Secretary under this section.

"HEALTH PROMOTION AND DISEASE PREVENTION DEMONSTRATION PROJECT

"SEC. 204. (a) The Secretary shall establish at least 1 demonstration project (but no more than 4 demonstration projects) to determine the most effective and cost-efficient means of—

"(1) providing health promotion and disease prevention services,

"(2) encouraging Indians to adopt good health habits,

"(3) reducing health risks to Indians, particularly the risks of heart disease, cancer, stroke, diabetes, anxiety, depression, and lifestyle-related accidents,

"(4) reducing medical expenses of Indians through health promotion and disease prevention activities,

"(5) establishing a program—

"(A) which trains Indians in the provision of health promotion and disease prevention services to members of their tribe, and

"(B) under which such Indians are available on a contract basis to provide such services to other tribes, and

"(6) providing training and continuing education to employees of the Service, and to paraprofessionals participating in the Community Health Representative Program, in the delivery of health promotion and disease prevention services.

"(b) The demonstration project described in subsection (a) shall include an analysis of the cost-effectiveness of organizational structures and of social and educational programs that may be useful in achieving the objectives described in subsection (a).

"(c)(1) The demonstration project described in subsection (a) shall be conducted in association with at least one—

"(A) health profession school,

"(B) allied health profession or nurse training institution, or

"(C) public or private entity that provides health care.

"(2) The Secretary is authorized to enter into contracts with, or make grants to, any school of medicine or school of osteopathy for the purpose of carrying out the demonstration project described in subsection (a).

"(3) For purposes of this subsection, the terms 'school of medicine' and 'school of osteopathy' have the respective meaning given to such terms by section 701(4) of the Public Health Service Act.

"(d) The Secretary shall submit to Congress a final report on the demonstration project described in subsection (a) within 60 days after the termination of such project.

"(e) The demonstration project described in subsection (a) shall be established by no later than the date that is 6 months after the date of enactment of the Indian Health Promotion and Disease Prevention Act of 1985 and shall terminate on the date that is 2 years after the date of enactment of such Act.

"(f) There are authorized to be appropriated $500,000 for the purpose of carrying out the provisions of this section, such sum to remain available without fiscal year limitation.".

COMMUNITY HEALTH REPRESENTATIVE PROGRAM

SEC. 5. Title I of the Indian Health Care Improvement Act (25 U.S.C. 1611, et seq.) is amended by adding at the end thereof the following new section:

"COMMUNITY HEALTH REPRESENTATIVE PROGRAM

"SEC. 107. (a) The Secretary shall maintain a Community Health Representative Program under which the Service—

"(1) provides for the training of members of Indian communities as health paraprofessionals, and

"(2) uses such paraprofessionals in the provision of health care to such communities.

"(b) The Secretary, acting through the Community Health Representative Program of the Service, shall—

"(1) provide a high standard of paraprofessional training to Community Health Representatives to ensure that the Community Health Representatives provide quality health care to the communities served, and

"(2) in order to provide such training, develop a curriculum that—

"(A) combines education in the theory of health care with supervised practical experience in the provision of health care,

"(B) provides instruction of, and practical experience in, health promotion and disease prevention activities, particularly—

"(i) nutrition,

"(ii) physical fitness,

"(iii) weight control,

"(iv) cessation of tobacco smoking,

"(v) stress management,

"(vi) control of alcohol and drug abuse,

"(vii) control of high blood pressure, and

"(viii) prevention of lifestyle-related accidents, and

"(C) provides instruction in the latest and most effective social, educational, and behavioral approaches to the establishment and maintenance of good health habits,

"(3) develop a system which identifies the needs of Community Health Representatives for continuing education in health care, health promotion, and disease prevention and develop programs that meet the needs for such continuing education, "(4) develop and maintain a system that provides close supervision of Community Health Representatives,

"(5) develop a system under which the work of Community Health Representatives is reviewed and evaluated,

"(6) explore ways to provide health care, health promotion, and disease prevention to the members of each Indian tribe in a manner which is consistent with the traditional health care practices and cultural values of such Indian tribe, and

"(7) adapt the programs of the Service to take into account any findings made under paragraph (6).".

○

Senator DECONCINI. The committee is anxious to hear the comments which all of the witnesses will be presenting today. Unfortunately, we only have 4 hours to go through the entire list of witnesses. All testimony will be made part of the record, and we will ask witness and each member of the panel of witnesses to please summarize their testimony so that we may have some time for questions and so that we can get through the full list.

It is now my pleasure to turn the meeting over to my good friend, Senator Bingaman.

Senator BINGAMAN. I thank you very much. Let me start by thanking Senator DeConcini and the Select Committee on Indian Affairs for their willingness to have this hearing and for his coming over this morning from Phoenix to conduct the hearing. I think it is a sign of the importance he attaches to the subject matter and the importance he attaches to the welfare of the Indian people of this country.

I want to also thank Congressman Richardson for his help in this bill in particular that's the subject of the hearing today on the house side. He's taken the leadership role there in pushing the same legislation that we've introduced in the Senate over on the House side, and I appreciate him doing that and also appreciate him being here today to participate in this hearing.

I believe Senator DeConcini said that all Americans are interested more today than they have been in the past about what can be done by the individual to improve the individual's health. Someone referred to a fitness revolution that is sweeping across the Nation, and we see more and more people interested in the subject of good nutrition and a positive life style as a way of improving health.

I think the beneficial effects of such health changes are well documented and documented in the medical literature that's coming out as well.

S. 400, which is the Indian Health Promotion and Disease Prevention Act of 1985, is the focus of the hearing today. And this bill attempts to focus on health promotion and extend that focus to American Indians.

It approaches Indian health from the perspective that it is a responsibility of Federal, State, tribal, and local governments and health agencies to provide the structure and the environment to help individuals make the changes in lifestyle that will improve their health.

Most importantly, it establishes health promotion and disease prevention services within the Indian Health Service. I believe, also, that only through an integrated approach by all of these elements can the maximum enhancement of Indian health be achieved.

The need for this type of approach is critical, and let me describe the current situation. According to the Office of Technology Assessment, and I believe we will get testimony here a little later on their findings, the health status for Indians has improved in the past decade. But for many diseases, the death rate is still greater than the U.S. population as a whole.

Even though Indians have a higher birth rate than the U.S. population as a whole, mortality rates for infants age 1 month to 1 year continues to be a major problem with a rate as high as 17.3

per 1,000 live births among some tribal groups. Indian people die younger than general U.S. population.

In 1981 only 5.5 percent of all deaths in the United States occurred under the age of 25, and 32 percent of the deaths occurred under the age of 65 for the population as a whole.

Among American Indians, however, 19 percent of the deaths occurred under the age of 25 and a full 62 percent occurred under the age of 65.

Among Indians, both male and female, accidents are the leading cause of death and result in a rate of 2½ times that of the U.S. population in general. Following accidents, Indians are more likely than the United States as a whole to die of chronic liver diseases, diabetes, pneumonia, influenza, homicide, suicide, and tuberculosis.

These statistics point to the fact that a more aggressive approach to health care is called for. No longer can the Indian Health Service look only at clinical care. It needs to complement its service to include more emphasis on prevention.

No longer can States rely on the Federal Government and the tribes, but States must also become an active partner. And most importantly, there is a great deal to learn from the Indian tribes themselves, who, before the word "prevention" was even coined, led a traditional lifestyle that was significantly healthier than many are able to lead today.

This is the first time that this committee will hear from witnesses on the subject of health promotion and disease prevention, and the development of this testimony will help to educate members of the committee, Members of the Senate and, hopefully, Members of the House, and will educate all those who are working for better health among Indian people.

Again, I thank you for having the hearing, and I appreciate the chance to participate.

[The full text of Senator Bingaman's opening statement follows:]

Opening Statement of Senator Jeff Bingaman

Mr. Chairman, thank you for being here today and participating in this hearing. I, too, look forward to testimony from this wide variety of witnesses on efforts to improve the well being of American Indians through prevention of disease and health promotion.

At this time, perhaps more than ever before, all Americans are interested in what they can do to improve their health and live fuller, more productive lives. A fitness revolution is sweeping across the nation. We see more and more people interested in good nutrition and in the positive lifestyle changes that can improve their health. The beneficial effects of such changes are known and acknowledged.

S. 400, the Indian Health Promotion and Disease Prevention Act of 1985, is the subject of today's hearing. This bill attempts to extend wellness and health promotion to American Indians. It approaches Indian health from the perspective that it is the responsibility of federal, state, tribal, and local governments and health agencies to provide the structure and the environment to help individuals make the changes in lifestyle that will improve their health. Most importantly, it establishes health promotion and disease prevention services within the Indian Health Service.

Only through an integrated approach can the maximum enhancement of Indian health be achieved.

The need for this type of approach is critical. Let me describe the current situation. According to the Office of Technology Assessment—the Project Director, Larry Miike, will be testifying later today—the health status for Indians has improved over the past decade. But for many diseases, the death rate is still greater than the U.S. population as a whole.

Even though Indians have a higher birth rate than the U.S. population as a whole, mortality rates for infants aged one month to one year continues to be a problem, with a rate as high as 17.3 percent per 1,000 live births among some tribal groups. Indian people die younger than the general U.S. population. In 1981, only 5.5 percent of all deaths in the United States occurred under the age of 25, and only 32.2 percent of the deaths were in those under the age of 65. Among American Indians, however, 19 percent of the deaths were in those under 25, and 61.6 percent were in those under age 65.

Among Indians, both male and female, accidents are the leading cause of death, and result at a rate two and a half times that of the U.S. population generally. Following, accidents, Indians are more likely than the U.S. as a whole to die of chronic liver diseases and cirrhosis, diabetes, pneumonia, influenza, homicide, suicide, and tuberculosis.

These statistics point to the fact that a more aggressive approach to health care is called for. No longer can the Indian Health Service look only to clinical care. It needs to complement its service to include prevention. No longer can states rely on the federal government and the tribes, but must become an active partner. And most importantly, there is much to learn from the Indian tribes, who before the word prevention was even coined, led a traditional lifestyle that encompassed a holistic approach to living.

This is the first time that this Committee will hear from witnesses on the subject of health promotion and disease prevention. The development of this testimony will help educate members of this Committee and the Senate, and will help educate all who seek better health for Indian people.

Senator DeConcini. Representative Richardson?

STATEMENT OF HON. WILLIAM B. RICHARDSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW MEXICO

Representative Richardson. Thank you very much, Senator DeConcini and Senator Bingaman. I appreciate the invitation to me to this Senate hearing. It was very kind of you to allow me to come.

And I want to commend both of you. First of all, Senator DeConcini, I wish to thank you for being such a good friend to New Mexico. You are New Mexico's third U.S. Senator. And I must say that I recall some legislation late last year relating to Navajo land claims that we desperately had to pass in the last minutes of the session. After having failed in the House, it was Senator DeConcini that, with his unique style of efficiency and maneuvering, got the bill passed through the Senate, and we got it passed through the House. Unfortunately, at the last minute, it was vetoed, but it was an important bill.

He is a true friend of the Navajo people and all the people in New Mexico, and I am just very pleased that he is here. I urge him to come back to New Mexico more often.

And, of course, Senator Bingaman, my colleague in the Congress, has made a major effort and a major achievement in the drafting of this bill. This is a bill that deals with the preventive aspects of health care. It deals with nutrition, with alcoholism, with physical fitness. And I think it's the key to the future to any health care, not just for native Americans, but for all Americans.

It deals with some very neglected aspects that we are going to be looking at today. I want to congratulate the Senator and his staff, too, for the comprehensive nature of the hearing.

I just looked at this witness list, and I think anybody that's anybody in health care of native Americans will be appearing today. This will be a rich document for the Congress to consider. And I am just here to listen and to learn.

I can't stay throughout the whole hearing because of many other commitments I have throughout the district. But, nonetheless, the Select Committee on Indian Affairs should be commended for their efforts in being here and for coming to my district of Gallup, NM, the heart of Indian land in this country. And I'd better stop there. I'll get into trouble, Senator.

But thank you so much for the invitation to appear with you today.

Senator DECONCINI. Congressman, thank you very much.

[Representative Richardson's prepared statement follows:]

BILL RICHARDSON
3D DISTRICT, NEW MEXICO

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CONGRESSMAN BILL RICHARDSON
STATEMENT ON
INDIAN HEALTH PROMOTION AND DISEASE PREVENTION ACT OF 1985
JUNE 1, 1985

FIRST OFF, I WANT TO WARMLY WELCOME SENATOR DECONCINI TO THE LAND OF ENCHANTMENT, AND ENCOURAGE HIM TO CROSS THE ARIZONA BORDER INTO NEW MEXICO MORE OFTEN.

SENATOR BINGAMAN, I AM DELIGHTED TO BE HERE AND APPRECIATE THE OPPORTUNITY TO PARTICIPATE IN TODAY'S HEARING. I WANT TO COMMEND MY COLLEAGUES IN THE SENATE FOR THEIR OUTSTANDING WORK AND SUPPORT OF SEVERAL INITIATIVES DESIGNED TO IMPROVE THE QUALITY OF LIFE FOR OUR NATIVE AMERICAN COMMUNITIES.

I AM ELATED AT THE PROSPECT OF SENATOR BINGAMAN'S INDIAN HEALTH PROMOTION AND DISEASE PREVENTION ACT BECOMING LAW AND FEEL IT IS AN IMPORTANT FIRST STEP IN THE RIGHT DIRECTION TO IMPROVE THE HEALTH AND WELL-BEING OF NATIVE AMERICANS AND TO REDUCE OVERALL HEALTH CARE COSTS.

PREVENTIVE SERVICE IS A NEGLECTED ASPECT OF THE INDIAN HEALTH CARE DELIVERY SYSTEM. IF WE ARE TO REACH HEALTH STATUS PARITY FOR NATIVE AMERICANS, ATTENTION MUST BE DIRECTED AND FOCUSED ON THE VARIOUS MEDICAL PROBLEMS THAT LEAD TO ADMISSIONS TO IHS HOSPITALS. I BELIEVE THAT IHS MUST LOOK AN EYE TO THE FUTURE AND AGRESSIVELY PURSUE A COMPREHENSIVE HEALTH PROMOTION AND DISEASE PREVENTION STRATEGY -- PROVIDING PROGRAMS AND INFORMATION ON ALCOHOL AND DRUG ABUSE. NUTRITION AND PHYSICAL FITNESS, AND OTHER LIFE STYLE CHANGES INDIVIDUALS CAN MAKE TO REDUCE THE OVERALL RISK OF DISEASE AND LEAD HEALTHIER LIVES.

I AM PLEASED TO INFORM YOU TODAY THAT I HAVE BEEN SUCCESSFUL IN INCORPORATING THE SPIRIT AND INTENT OF SENATOR BINGAMAN'S BILL INTO THE HOUSE VERSION OF THE INDIAN HEALTH CARE REAUTHORIZATION ACT. THE HOUSE BILL HAS CLEARED BOTH THE

HOUSE ENERGY AND COMMERCE AND INTERIOR AND INSULAR AFFAIRS COMMITTEES, AND IS ON ITS WAY TO THE FLOOR OF THE HOUSE OF REPRESENTATIVES FOR FINAL PASSAGE. MY INITIATIVE DIRECTS THE SECRETARY TO EVALUATE PREVENTIVE HEALTH, HEALTH PROTECTION AND HEALTH PROMOTION NEEDS OF NATIVE AMERICANS AND IDENTIFY:

- THE SERVICES NECESSARY TO MEET SUCH NEEDS
- THE RESOURCES REQUIRED
- THE RESOURCES THAT ARE ALREADY AVAILABLE TO CARRY OUT PREVENTIVE HEALTH PROTECTION AND PROMOTION NEEDS OF NATIVE AMERICANS

IN ADDITION, MY INITIATIVE REQUIRES BY REGULATION THAT EACH INDIAN TRIBE IDENTIFY SPECIFIC PREVENTIVE HEALTH, HEALTH PROTECTION AND HEALTH PROMOTION NEEDS IN THEIR OWN PLAN SUBMITTED TO THE SECRETARY AND DEVELOP A COMPREHENSIVE BLUEPRINT AND SCHEDULE FOR THE IMPLEMENTATION OF SUCH SERVICES BY IHS.

SENATOR BINGAMAN, YOUR BILL GOES ONE STEP FURTHER IN THAT IT AUTHORIZES A DEMONSTRATION PROJECT TO DEVELOP THE MOST EFFECTIVE AND COST EFFICIENT MEANS OF PROVIDING HEALTH PROMOTION AND DISEASE PREVENTION SERVICES. I SUPPORT THE CONCEPT OF DEVELOPING A DEMONSTRATION PROJECT TO IMPLEMENT THE PROVISIONS OF YOUR BILL AND WILL BE A VOCAL ADVOCATE AS AN EXPECTED MEMBER OF THE HOUSE/SENATE CONFERENCE COMMITTEE ON THE INDIAN HEALTH CARE REAUTHORIZATION ACT.

ALONG THE LINES OF PREVENTIVE HEALTH CARE PROMOTION, I WANTED TO BRING TO YOUR ATTENTION AND TO THE ATTENTION OF OUR NORTHWESTERN NEW MEXICO COMMUNITIES ANOTHER LEGISLATIVE INITIATIVE THAT I HAVE BEEN SUCCESSFUL IN ADVANCING IN THE CONGRESS. MY AMENDMENT IS OF IMPORTANCE TO THE GALLUP COMMUNITY AND IS NOW PART OF THE HOUSE VERSION OF THE INDIAN HEALTH CARE REAUTHORIZATION ACT. MY INITIATIVE WILL MAKE A GRANT AVAILABLE TO THE NAVAJO TRIBE TO ESTABLISH A DEMONSTRATION PROGRAM IN GALLUP TO REHABILITATE ADULT NAVAJOS SUFFERING FROM ALCOHOLISM OR ALCOHOL ABUSE. $400,000 PER YEAR FOR THE NEXT THREE FISCAL YEARS WOULD BE AUTHORIZED TO BE APPROPRIATED FOR THE PROGRAM AND NOT MORE THAN 10 PERCENT OF THE FUNDS COULD BE USED FOR ADMINISTRATIVE PURPOSES. MY INITIATIVE WILL INCLUDE FOLLOW-UP AND EVALUATION BY THE NATIONAL INSTITUTE OF ALCOHOL ABUSE AND ALCOHOLISM SO THAT CONGRESS CAN CONSIDER REPLICATION OF REHABILITATION PROGRAMS IN OTHER NATIVE AMERICAN COMMUNITIES.

OVER 50 PERCENT OF ALL ADMISSIONS TO NAVAJO IHS FACILITIES ARE ALCOHOL-RELATED. AN ESTIMATED 44 PERCENT OF THE NAVAJO PEOPLE ARE DIRECTLY OR INDIRECTLY AFFECTED BY ALCOHOLISM -- MY NAVAJO ALCOHOLISM DEMONSTRATION PROJECT WOULD MARK THE FIRST TIME THAT THE CONGRESS WOULD TAKE A POSITIVE STEP TOWARD IMPLEMENTING A SCIENTIFICALLY CONTROLLED AND CAREFULLY MONITORED REHABILITATION PROGRAM AMONG THE NAVAJO PEOPLE. THE CITY OF GALLUP HAS AN EXISTING FACILITY IN FRIENDSHIP SERVICES WHICH HAS BEEN OFFERED AS A PLACE TO HOUSE A DEMONSTRATION PROJECT.

WHILE WE HAVE MADE SOME PROGRESS IN THIS COUNTRY IN RAISING THE HEALTH STATUS OF OUR INDIAN PEOPLE IT STILL FALLS FAR BELOW THE U. S. POPULATION AS A WHOLE. NOT LONG AGO I RECEIVED A LETTER FROM AN INDIAN HEALTH CLINIC WORKER WHO POINTED TO THE NEED FOR PREVENTIVE ACTION WHEN HE WROTE, "I HAVE OBSERVED THAT THE AVERAGE NATIVE AMERICAN WILL NOT CONSULT PROFESSIONAL HEALTH AID UNTIL SERIOUSLY ILL." THIS IS A TREND WE MUST REVERSE. IN EDUCATING PEOPLE HOW TO TAKE CARE OF THEMSELVES, WE CAN START SEEING RESULTS IN IMPROVING HEALTH AND LOWERING MEDICALS COSTS.

SENATOR BINGAMAN'S BILL FOCUSES ATTENTION ON A LONG NEGLECTED ASPECT OF INDIAN HEALTH AND CALLS FOR THE DEVELOPMENT OF A NATIONAL PREVENTIVE HEALTH, HEALTH PROTECTION AND HEALTH PROMOTION POLICY WITH A COMPREHENSIVE PLAN AND TIMETABLE TO IMPLEMENT IT.

I LOOK FORWARD TO HEARING FROM THE MANY WITNESSNESS THAT ARE HERE TODAY, AND WANT TO THANK YOU AGAIN FOR THE OPPORTUNITY TO PARTICIPATE IN THIS IMPORTANT HEARING.

Senator DECONCINI. We will proceed now with the hearings with the understanding that we ask the witnesses to please summarize. I am going to ask Senator Bingaman to call the witnesses here. This is his home State, and I'm here to learn, also.

We want to thank the staff of Senator Bingaman and certainly June Tracy of the Indian Select Committee, who is with my staff, who has done a great deal of work here, and all those who have participated.

Senator Bingaman?

Senator BINGAMAN [presiding]. Thank you very much. Let me, also, just before I call the first witness say how much I appreciate the staff of the select committee and Senator DeConcini's staff and my own staff, in particular Faith Roessel and Becky Bustamante, for the work they put into this effort.

According to the list I have, Larry Miike, who is the Project Director for Indian Health Assessment in the Office of Technology Assessment, was scheduled to be our first witness. Is Larry here at this time? Larry, please come forward. We're looking forward to hearing your testimony.

Dr. MIIKE. Thank you, Senator Bingaman, Senator DeConcini, Representative Richardson.

Senator BINGAMAN. Can you folks here us back there? Why don't we just take a very short recess.

[Brief recess.]

Senator BINGAMAN. I think it's just a matter of just really getting into it, Larry. Those of us with big mouths are not going to have any trouble here today.

STATEMENT OF DR. LAWRENCE MIIKE, PROJECT DIRECTOR, INDIAN HEALTH ASSESSMENT, OFFICE OF TECHNOLOGY ASSESSMENT, WASHINGTON, DC

Dr. MIIKE. Senator DeConcini, Senator Bingaman, and Representative Richardson, I am Dr. Lawrence Miike, Senior Associate with the Congressional Office of Technology Assessment and Project Director of the OTA's current assessment of American Indian and Alaska Native health care.

I submitted my written testimony, so I will summarize my statement and, perhaps, augment it a little bit since I have just come from South Dakota visiting the Sioux Tribes in that area.

For those of you who are not familiar with the Office of Technology Assessment, we are one of four agencies of the Congress, the other three being the Library of Congress and its Congressional Research Service, the General Accounting Office and the Congressional Budget Office.

At the present time, we are currently about halfway through our assessment of Indian Health Care and expect to complete our work by the beginning of 1986. One of our project activities is a series of regional meetings and site visits designed to learn firsthand about the health issues and problems at the local level and to meet with as many tribal representatives and health care providers as possible.

While we have not completed these area visits, certain themes keep recurring that are relevant to today's hearings. I want to depart briefly from my written testimony and relate to you some experiences that I've just had up in South Dakota, which would, I think, highlight the purpose of this hearing.

While I was out there, we had a very strong wind storm like we've had down here. Several houses were destroyed. The newspaper reported 74 people homeless, $60,000 to $70,000 damage. And people said, "$60,000 to $70,000 damage for 74 people being homeless? That can only happen on Indian land."

And, of course, what they meant was there were probably 15 people living in a house together. And that's directly related to the kinds of problems that that tribe still has, which is unsanitary conditions leading to a lot of respiratory illnesses, skin diseases, and even kinds of problems where you're just having trouble taking care of cuts, where you just don't have clean water to take care of your usual cuts and bruises.

Also, up in that area, alcoholism, as is true throughout most of Indian country, is a big problem. On the Pine Ridge Reservation it is estimated that about half of their women have alcoholism problems of one kind or another.

And, as many of you in the audience know, that has a direct effect on pregnancy and the fetal alcohol syndrome. Also, we're beginning to see a lot more diabetes in the area, diabetes appearing in families that never have had a history of diabetes before. And that will be directly related in terms of long-term costs for such things as renal dialysis, amputations, and other sequelae of long-term diabetes.

Many tribes we have visited not only are acutely aware of these problems, but are also trying to do something about them. In the Southwest, in this area, for example, the Indian Health Service has long provided direct medical services through reservation-based clinics and hospitals and through metropolitan-based specialty-referral medical centers for Indians.

Several tribes now have tribal health departments or health authorities and operate their own Preventive and Environmental Health Programs funded by grants, self determination contracts and tribal funds to augment the direct medical services provided by the Indian Health Service.

These tribes have expressed their intention to eventually run these medical services themselves, but express fears that because of current budgetary constraints and cutbacks, they will not receive comparable levels of funding that the IHS now receives for conducting these activities.

Consequently, though some tribal health authorities have examined their health needs in terms of both preventive and direct care services, the integration of these services is handicapped by the fact that preventive services are in the hands of the tribes, while direct medical services is still under the direct control of the Indian Health Service.

The current fiscal climate has also led to pressures to limit IHS programs to provide only direct medical services. This has also led to preventive programs that are being assumed by the tribes being cut, thereby weakening the tribal health programs and tribal self-determination.

Despite the truisms that medical services cannot be viewed in isolation from preventive health efforts and that prevention is cheaper in the long term, the fact remains that when today's dollars are what is being competed for, the need for direct services almost always wins.

Furthermore, tribes come in and complain that the Indian Health Service is not a partner in determining and providing for tribal health needs, but acts more like a parent. This criticism of the IHS had increased because of concerns that budget decisions will be made on the basis of fiscal criteria and not on the basis of health priorities as determined jointly by the tribes and the IHS.

S. 400 calls for the development of 3 and 10 year comprehensive plans for health promotion and disease prevention services to Indians.

First, tribal involvement needs to be solicited from the start. Second, some tribes have been addressing this issue for years and can provide valuable advice, not only to the IHS, but also to other tribes with less resources. Third, how health promotion and disease prevention activities are coordinated with direct medical services will depend on the extent to which the Indian Health Service continues as a direct provider of medical services versus the extent to which tribes decide to assume responsibility for operating these medical services.

Furthermore, since tribal health authorities seek funds from other than Indian Health Service sources for some prevention related programs, such as the WIC or Women, Infants and Children Program, it is at the tribal level that these other sources can be integrated with the health promotion and disease prevention program initiated by the IHS.

In sum, my testimony has concentrated on some of the policy implications of S. 400 as it relates to tribal needs and activities in the area of health promotion and disease prevention.

Others here will provide you with more information on the needs and possible approaches. I am sure that the tribes would welcome this initiative, but the bottom line for them will be whether or not they have a real impact on defining those needs, whether the program will be relevant to their local circumstances, whether these activities will augment the direct services dollars or will compete with direct medical services for limited dollars and what responsibilities and authorities they will have for these programs. Thank you.

[Dr. Miike's prepared statement follows:]

TESTIMONY OF LAWRENCE MIIKE
OFFICE OF TECHNOLOGY ASSESSMENT
U.S. CONGRESS
ON
SENATE BILL 400:
THE INDIAN HEALTH PROMOTION AND DISEASE PREVENTION ACT OF 1985
FIELD HEARINGS HELD AT
GALLUP, NEW MEXICO
JUNE 1, 1985

I am Dr. Lawrence Miike, Senior Associate with the Congressional Office of Technology Assessment (OTA) and project director of a current assessment of American Indian and Alaska Native health care.

OTA was requested by the House Committee on Energy and Commerce and its Subcommittee on Health and the Environment to assess: 1) the health status of American Indian and Native Alaska people who are eligible for care through the Indian Health Service; 2) the most appropriate mix of medical and health services and technologies in light of the health needs of the eligible population; 3) the organization of health delivery systems, with emphasis on adequate and equitable access to services and technologies, health outcomes, and cost effectiveness; and 4) catastrophic health care needs, and current and alternative financing arrangements for those needs.

This request was also supported by the Senate Select Committee on Indian Affairs. Senator Ted Stevens (R-Alaska) and Congressman Morris Udall (D-Arizona), acting in their capacities as Chairman and Vice-Chairman, respectively, of OTA's Congressional Board, have also communicated their interests in this assessment to us because of their large constituencies of Alaska Natives and American Indians. As you know, Congressman Udall is also Chairman of the House Interior and

Insular Affairs Committee, which has primary jurisdiction over Native American programs. We are currently about half-way through the project and expect to complete our work by the beginning of 1986.

One of our project activities is a series of regional meetings and site visits designed to learn firsthand about the health issues and problems at the local level and to meet with as many tribal representatives and health care providers as possible. While we have not completed these area visits, certain themes keep recurring that are relevant to today's hearings.

I understand that other witnesses at this hearing have or will provide you with detailed analyses of disease patterns among Native Americans, how these diseases contribute significantly to sickness and death, the costs of providing direct medical services as the result of these diseases, and the chances of lowering the incidences of some of these diseases through preventive programs such as those addressed by Senate Bill 400. For my part, let me augment these presentations by sharing with you some of the observations garnered from both our overall review of Indian health care and the impressions we have gained from these area meetings and site visits.

First, there is no question that preventive health care works. The classical example is vaccines, and a current, important project is the detection and prevention program against hepatitis B in Alaska. On a smaller scale, meningitis from hemophilus influenza bacteria was discovered as a significant problem in children at the White Mountain Apache reservation, and the Johns Hopkins School of Medicine currently has a demonstration program on the reservation to vaccinate against this disease.

Prevention of meningitis not only saves lives and avoids significant disabilities in survivors, but it also saves the high costs of treating meningitis and its disabling effects on the central nervous system. High costs are common in many of the types of diseases that could be prevented or at least mitigated. In the maternal and child health area, adequate maternal nutrition to decrease the incidence of prematurely-born infants, and avoidance of alcohol during pregnancy to prevent fetal alcohol syndrome, are other examples of measures to combat largely preventable problems.

Renal failure from hypertension or diabetes -- two largely controllable diseases -- and the resultant need for dialysis, is another growing problem. In the southwest, transportation costs alone are a significant factor. In the Phoenix area, several tribes have to routinely drive or fly their dialysis patients to Phoenix three times a week on round-trips of several hundred miles. In addition to the costs, imagine being a dialysis patient who has to leave home in the early morning dark, be hooked up to a dialysis machine during the day, and then have to return home late at night, only to have to repeat it all over again the day after tomorrow -- indefinitely. It is no wonder that some of these patients choose not to be dialyzed, even if it means certain death.

Alcoholism and alcohol-related diseases and injuries continue to be the most pervasive problem for many tribes. The problem so far has been intractable. The causes of alcoholism among Native Americans have many roots and consequently, need many approaches. Alcoholism treatment programs are only one approach. For example, the Headstart program is important not only for its direct impact on children, many of whom are children of alcohol abusers, but also for teaching parents -- many of whom have just left childhood themselves -- the art of parenting. This program, and continued efforts to keep these children in school so that they will be better prepared for adult life, are outside the medical sphere but are essential if educational levels and hence, job opportunities, are to increase and alcoholism hopefully decreases among Native Americans. The need for such multiple approaches to the prevention and control of alcohol abuse makes the impact of any single program, however broad, difficult to assess, but it is clear that a simple medical approach is insufficient and comes too late for most alcoholics.

Many tribes we have visited are not only acutely aware of these problems, but are also trying to do something about them. In the southwest, the Indian Health Service has long provided direct medical services through reservation-based clinics and hospitals and through metropolitan-based specialty referral medical centers for Indians. Several tribes now have tribal health departments or health authorities and operate their own preventive and environmental health programs funded by grants, self-determination contracts, and tribal funds, to augment the direct medical services provided by the Indian Health Service. These tribes have expressed their intentions to eventually run these medical services themselves but express fears that, under current budgetary constraints and cutbacks, they will not receive comparable levels of funding that the IHS now receives for conducting these activities. Consequently, though some tribal health authorities have examined their health needs in terms of both preventive and direct care services, the integration of these services is handicapped by the fact that preventive services are in the hands of the tribes, while direct medical services is still under the direct control of the Indian Health Service.

The current fiscal climate has also led to pressures to limit IHS programs to provide only direct medical services . This has also meant that the preventive programs that have been assumed by the tribes are being cut, thereby weakening tribal health programs and tribal self-determination. Despite the truisms that medical services cannot be viewed in isolation from preventive health efforts and that prevention is cheaper in the long-term, the fact remains that when today's dollars are what is being competed for, the need for direct services always wins. The way funding is provided by the Indian Health Service reflects this situation; clinical care is part of the basic appropriations, while prevention-oriented programs such as the community health representative program are provided through legislation that needs reauthorizing legislation.

Furthermore, tribes commonly complain that the Indian Health Service is not a partner in determining and providing for tribal health needs but acts more like a parent, dictating to the tribes what they need and will get in the way of medical and health-related services. This criticism of the IHS has increased because of concerns that budget decisions will be made purely on the basis of fiscal criteria, and not on the basis of health priorities determined jointly by the tribes and the IHS.

This leads me to the following conclusions based on our ongoing assessment of health care for Native Americans.

We know what health problems are preventable, even some of the solutions, and what further research and demonstration needs to be conducted. What we need is a strategy acceptable to the tribes, not only because we deal with them on a government-to-government basis, but also because prevention programs will often mean impinging on native customs, traditions, and diets, and there needs to be an accommodation of these traditional practices with modern health care practices. The tribes are also aware of general budget restraints and the fact that they are facing reduced or no growth funding. But they do not understand why they fail to have more impact in selecting which health programs are to be cut and which are to be preserved.

Learning is a two-way street. Some tribes have been looking at these issues for years, and as noted earlier, have even organized their tribal health authorities to integrate medical and preventive health services. The Indian Health Service is still largely a clinic and hospital-driven system, and it must learn about and be committed to preventive approaches.

Perhaps the best situation would be for health promotion and disease prevention programs to be integrated with direct medical services in the basic appropriations process; i.e., that these activities be considered part and parcel of the services provided through the Indian Health Service through the authority of the Snyder Act. This integration would be a difficult objective, especially in times of budgetary constraints; but that seems to be one of the ultimate objectives of Senate Bill 400. Again, however, tribal input needs to be solicited, because an integration of medical and preventive health services has been the objective of the tribal health authorities, even under current constraints whereby direct services are still under the control of the Indian Health Service. But even though an integration of direct and preventive health services is the approach of the typical tribal health authority, tribes may view this integration at the IHS level as another method of cutting down on direct services. Thus, they may prefer to attempt this integration at the tribal level in conjunction with assuming more of the direct medical care now provided by the IHS.

Senate Bill 400 calls for the development of three- and ten-year comprehensive plans for health promotion and disease prevention services to Indians. First, tribal involvement needs to be solicited from the start. Second, some tribes have been addressing this issue for years and can provide valuable advice not only to the IHS, but also to other tribes with less resources. Third, how health promotion/disease prevention activities are coordinated with direct medical services will depend on the extent to which the Indian Health Service continues as a direct provider of medical services versus the extent to which tribes decide to assume more responsibility for operating these medical services. Furthermore, since tribal health authorities seek funds from other than Indian Health Service sources for some prevention-related programs (e.g., the WIC, or Women, Infants, and Children program), it is at the tribal level that these other sources can be integrated with a health promotion/disease prevention program initiated by the IHS.

In sum, my testimony has concentrated on some of the policy implications of Senate Bill 400 as it relates to tribal needs and activities in the area of health promotion/disease prevention. Others at this hearing will have provided you with information on the needs and possible approaches. I am sure that the tribes will welcome this initiative, but the bottom line for them will be whether or not they have a real impact on defining those needs, whether the program will be relevant to their local circumstances, whether these activities will augment their direct medical services dollars or will compete with direct medical services for limited dollars, and what responsibilities and authorities they will have for these programs.

Senator BINGAMAN. Senator DeConcini, do you have any questions?

Senator DECONCINI. Yes; let me ask one question, if I might, Mr. Chairman. Is it possible, Larry, to say at this point from the data which you have seen, to say what percentage of the health problems experienced by the Native American communities are preventable?

Dr. MIIKE. I couldn't give you an exact percentage. I would say a significant percentage. For example, the statistic on Native American infant mortality, about 17.1 per 1,000 live births, there are some tribes that have as high as 66 percent.

And the U.S. average, the general average, right now is fairly close to 10 percent.

Senator DECONCINI. So S. 400 would certainly help us in reducing those percentages and being able to have some hard facts to——

Dr. MIIKE. Yes. I think there are many——

Senator DECONCINI [continuing]. To address on the preventive side.

Dr. MIIKE. I think there are many diseases that are preventable. Some of them are fairly simple, the infectious type diseases where you just need good housing and good sanitation and good water supply.

Others may be more difficult in the diabetes area, the alcoholism area. But all of these problems are well known to both the IHS and the tribes.

Senator DECONCINI. Thank you. I just want to compliment Larry and the Office of Technology Assessment for the fine work that they do for the Congress.

Senator BINGAMAN. Bill, did you have some questions? Go ahead.

Representative RICHARDSON. Doctor, how much is the issue one of funding and not one of policy? The Indian Health Service, in my judgment has very competent people. But they don't have the skills or the resources to literally do everything right now especially in this fiscal year.

Does it make sense to develop an Indian policy in health care—and, by the way, I think that Senator Bingaman's bill will become law because it is in both the Indian health care bills in the House—and does it make sense to look at funding options, in other words, to implement legislation like this; such as, should we be doing more contracting out with private facilities, with private physicians, should IHS increase that option. And, second, does it make sense to join forces with other Federal facilities?

For instance, in the bill that we have in the House, we put in an amendment that allows for greater joint participation between the VA hospitals and the IHS. Do we need those two kinds of options to become more efficient in the funding and reducing costs, but maybe improving the cost of health care because, frankly, I think the IHS budget is literally devastated this year. And I don't see how we can implement even the minimal kind of efforts that are needed at the lowest possible level.

Dr. **Miike**. I think, obviously, both policy and budget are related. I think you'll start hearing from the tribes after I testify that, especially in the area of self-determination, taking over services, budget is one of the big constraints.

They are reluctant. Many tribes are reluctant to take it over because they don't think that they will be getting the same amount of resources that have been provided to them directly.

Senator **DeConcini**. But do you support more contracting out and more joint efforts with other Federal health agencies?

Dr. **Miike**. That depends. I think in terms of VA, that depends on where these other hospitals are. I think that the major area is not so much in terms of other Federal facilities, but other Federal sources of funds, Medicare and Medicaid funds, and whether that's going to be used to augment IHS funds or whether that's going to be used to replace IHS funds.

Senator **Bingaman**. Thank you, Senator. Let me just ask one final question, Larry. In your research, have you come across an example or a few examples of very good programs that some tribes or pueblos are pursuing in preventive health measures, such as what we're describing here today? Are there some examples that the rest of the country could emulate?

Dr. **Miike**. I think I had better leave that for the others to talk about because then we're going to get into, I think, issues of pride among the tribes, so I would rather leave that up to the tribes to give you that.

Senator **Bingaman**. All right. Thank you very much. We appreciate your testimony and appreciate you being here today.

According to the list that I have here, the first panel we have is a panel, a tribal panel, with Anita Levaldo, who is the acting executive director of the Division of Health Improvement Services for the Navajo Tribe in Window Rock. And she is accompanied by Michael Lincoln, Tony Secatero and Kenneth Cody.

I gather—let me just ask, is the intention that we would hear this testimony and then get Gilbert? OK.

Anita, welcome to the hearing, and we look forward to your testimony.

STATEMENT OF ANITA LEVALDO, ACTING EXECUTIVE DIRECTOR, DIVISION OF HEALTH IMPROVEMENT SERVICES, NAVAJO TRIBE, WINDOW ROCK, AZ; ACCOMPANIED BY MICHAEL LINCOLN, DIRECTOR, NAVAJO AREA INDIAN HEALTH SERVICES, WINDOW ROCK, AZ; TONY SECATERO, PRESIDENT, CANONCITO BAND OF NAVAJOS, AND BOARD MEMBER OF THE NATIONAL INDIAN HEALTH BOARD, CANONCITO, NM; AND KENNETH CODY, NAVAJO NATION COUNCIL ON AGING, WINDOW ROCK, AZ

Ms. Levaldo. Members of the committee, I would like to express my appreciation for being here this morning and having the opportunity to present the Navajo Nation testimony regarding the S. 400, known as the Indian Health Promotion and Disease Prevention Act of 1985.

First of all, I'd like to say that Senator Bingaman should be complimented and congratulated for his efforts in shifting the emphasis in Indian Health programs to disease prevention and health promotion rather than crises and oriented types of care, which Indian Health programs have been subject to over the many years.

The Navajo traditional ways have always emphasized prevention, prevention against illness and promoting healthy lifestyles. So we feel that this bill is in line with what the Navajo way of thinking is as far as gaining harmony within oneself and that illness is a state of disharmony and imbalance which may cause or result from interference in meeting basic human needs.

As far as the Navajo Nation, the types of programs that we advocate and that we utilize all have a health promotion and health prevention activity. One of our major programs is the Community Health Representative Program.

And in this bill, this is also highlighted, and we would like to mention significantly that this is a primary program on the reservation that does provide health prevention activities to not only communities. They affect almost every person on the reservation through their services.

And we appreciate that the CHR Program is highlighted in the bill. As far as disease trends among the Navajos over the years, in the past, at least 20 years ago, many of our problems have been related to infectious diseases, such as pneumonia and tuberculosis. Also, infant mortality and morbidity rates were always on the increase.

However, now that shift has changed. Now, the diseases that we're faced with are chronic diseases. And many of these diseases are preventable diseases. And that is why we feel that this bill is very important for the health and well-being of Navajo people as well as Indian people in general.

And so I'd like to also mention that this bill has implication for policy issues and resource allocations. The shift is now from actually—the shift is from direct medical care to health promotion, and the tribe has always been involved in health promotion activities, and we feel that it's very important that this aspect be brought into the Reagan administration.

In Indian Health Service-proposed budget deliberations, it was indicated that the health promotion-prevention activities were to be a priority. However, the resources did not necessarily follow.

When people start cutting budgets, it is always prevention and promotion activities, which are always the first to go. And we would hope that through this bill that the prevention and promotion activities would be a priority as opposed to something that we can live without.

This is, in summary, what our lengthy written testimony has indicated, and I will allow time for the testimony of my counterparts to do likewise. Thank you.

[Ms. Levaldo's prepared statement follows:]

TESTIMONY OF THE NAVAJO NATION
ON
SENATE BILL 400,
THE INDIAN HEALTH PROMOTION AND DISEASE PREVENTION ACT OF 1985

Presented before the
Senate Select Committee on Indian Affairs
Gallup, NM
June 1, 1985

Mr. Chairman, members of the Committee, I would like to express my appreciation for the opportunity to appear here today to present to you the concerns of the Navajo people regarding Senate Bill 400, known as the "Indian Health Promotion and Disease Prevention Act of 1985."

Let me begin by saying that Senator Bingaman is to be congratulated for his efforts to shift the emphasis in Indian health programs to disease prevention and health promotion activities. Evidence continues to mount that these activities can have a significant impact on both health status and thus health systems utilization and costs. Viable alternatives to expensive clinical treatment for largely preventable health problems do exist, yet the Reagan Administration has targeted its increasingly limited resources on treatment rather than prevention and promotion and chosen to ignore what we Navajos have known for centuries.

Navajo traditional ways recognize the importance of actively taking measures to prevent illness and promote healthy life-styles. Man's path is called "the corn pollen path" by our elders, symbolizing a balanced and harmonious existence. The goal of healthful living is "se ahnaghaii Bei kee Hozhon," the essence of harmony. Harmony is health. Harmony is beauty. Harmony is happiness. Our culture promotes these values and also prescribes a variety of important ritual and behavioral actions to be used to achieve these ends.

A brief look at the recent history of disease trends among our people provides ample evidence that (1) prevention and promotion activities have had a major impact on Navajo health status and (2) emerging patterns of illness and disability can be effectively addressed through prevention and promotion efforts. In 1960, 40% of Navajo deaths occured in children under the age of one year. By 1980, this figure had plummeted to 8%, an improvement of enormous proportions, yet far in excess of the national average of 2%. Significantly, this trend was associated with an increase in the percentage of Navajo homes with safe water and sanitation facilities, from less than 20% in 1973 to almost 65% in 1981. Clearly, infectious diseases affecting infant mortality and morbidity, such as enteritis, pneumonia, tuberculosis, dysentary, strep, and otitis, have responded to changes in Navajo lifestyle associated with improved sanitation practices.

Since 1960, chronic diseases have continued to grow in importance on the Navajo Nation. The cancer mortality rate has more than doubled. Death due to heart disease and other circulatory problems has almost doubled. The leading cause of death now among Navajos is accidents, most of which involve motor vehicles and alcohol intoxication. As a result, 51% of Navajo deaths occur between the ages of 20-65, compared to 30% in the U.S. population. In addition, stroke, diabetes, end stage renal disease, and behavioral problems including alcoholism, suicide, and homicide, continue to increase in distressing proportions.

Thus, in one sense, though our life expectancy still lags far below that of the national average, Navajos are healthier now than we were two decades ago. However, the ills that befall us today are the chronic debilitating diseases of an aging population which are costly to treat, which reflect changing behavioral characteristics of our population, and which can be prevented. The scope of disease prevention and health promotion activities encompassed in S. 400 and their appropriate interventions constitute an effective mechanism, we believe, by which to successfully address the changing epidemiology and health status problems of Navajo people.

We believe that it is crucial to link the broader policy, resource allocation, and planning provisions and implications of Senate Bill 400 to the inventory of prevention and promotion activities contained in the bill.

(1) Policy. The bill provides a strong foundation of policy support for (a) the incorporation of disease prevention and health promotion as integral parts of the model of medical and health care currently utilized by Indian Health Service and (b) the application of prevention and promotion standards, established by the government for the nation, to the health of Indian people. This approach acknowledges that (1) the health of Indian people cannot be raised significantly without adoption of an epidemiologically sound, community-based public health model of care and (2) Indian people should seek a level of health status equivalent to the health status of the nation as delineated in the Public Health Service national health objectives.

This is a major improvement over the fuzzy, unclear policy guidance contained in the FY1986 Indian Health Service budget request, which highlights prevention, while ear-marking resources to primarily clinical care. In addition, this policy is fully consistent with current Navajo Nation health policy: (1) medical care for Indian people is a direct trust responsibility of the Federal government which we see no need to change by entering into the direct clinical care business and (2) disease prevention and health promotion, supported under Federal trust responsibility, are efforts which we believe will benefit most significantly by Tribal intervention.

(2) Resource allocation. Senate Bill 400 presents a persuasive argument in favor of revamping the way in which IHS allocates its resources. Historically, IHS resources have been distributed on the basis of what is required to maintain existing program operations, with little or no weight given to population, utilization and workload, or epidemiological variables. The "equity" approach to allocating new resources, designed to address geographic maldistribution of manpower and thus dollars, appears to have had little impact on this situation. Moreover, nowhere in the system is the inequitable balance in favor of clinical services over "community health services," which include prevention and promotion activities, addressed.

The epidemiological model of health care delivery which S. 400 would implement embodies an empirical logic in which we have great faith. Priority health problems are targeted for special attention in the resource allocation process. As health status changes and new trends emerge, resources are shifted and allocated accordingly. Let me quickly say that we do not advocate halting clinical care. It simply seems poor rationale to establish policy which funnels resources into routine clinical care areas at the expense of high priority interventions of a prevention/promotion nature. Innovative allocation of scarce resources, from government, state, and tribal sources, in a mix determined to be most effective in a planned, cooperative, coordinated effort, is clearly called for. Thus, the provisions of S. 400 should be reflected in authorization levels of S. 277 (H.R. 1426) and in the appropriation requests for FY1986 for IHS and for block grants.

(3) Planning. It is important to recognize that the Navajo Nation, as well as many other tribes, currently possesses the capability to undertake the needs assessment and health planning provisions of S. 400. Ironically, the capability is not to be found in the "tribal specific health planning process" of IHS genesis, which is nothing more than the in-house "resource requirement methodology." For example, the Navajo Nation Master Health Plan, an integrated approach to the planning requirements of the National Health Planning Act and the Indian Health Care Improvement Act, embodies a population based approach to planning, including health promotion/prevention. The plan has been in existence since 1979, at which time it was adopted by the Navajo Tribal Council, and is currently being updated by the Navajo Health Systems Agency. The MHP fully addresses the planning provisions contained in S. 400.

The health planning process we advocate for implementation of S. 400 is important not only because it is based on a culture-specific, community-oriented epidemiological model of health care delivery, but also because it constitutes an effective way for the Tribe itself to monitor changes in health status and improvements in the health of Navajo people. However, this function can only be served if all providers - government, state, and Tribe - participate in a consolidated, comprehensive patient information and program data system, one which will reflect not only IHS facility-based workload, but community-level statistics as well, for a true profile of prevailing health status. This will enable tribes, IHS, and other

Indian health providers to plan and allocate resources according to current needs and problems.

There are two specific provisions of S. 400 that require special mention before I close. (1) The prevention/promotion demonstration projects in Section 204, designed presumably to illustrate effectiveness (both on an outcome and cost basis) must not be used as merely vehicles to prove what is already known. Instead, they should emphasize the necessary linkages between (a) innovative methodologies which effectively couple clinical care and prevention/promotion and (b) selected strategies and interventions, required resources, and expected/desired outcomes particularly the utility and effectiveness of these models for Indian people. We know, for example, what impact "reduction in the misuse of alcohol and drugs" will have on the "control of accidental injuries." What we do not know is how to most effectively maximize this impact. We know that Navajo children who live in isolated areas with unpaved roads appear in IHS clinics with more severe illnesses than their counterparts who have access to clinics on paved roads. What should be the intervention? Health education? Outreach? Paved roads? Four-wheel drive vehicles? It is our desire to subject high priority health problems, especially those of a behavioral etiology, such as alcohol abuse, accidents, and diabetes, to this kind of scrutiny.

(2) S. 400 would provide for the continuation of the Community Health Representative (CHR) Program, which once again is threatened by extinction at the hands of the Reagan Administration. By means of solid paraprofessional training, it would also use the program as a major vehicle to address identified prevention/promotion objectives. As we have noted in earlier

appropriations testimony before this committee, extinguishing the CHR Program serves no rational purpose, not even that of fiscal austerity. We are prepared to postulate that a model Navajo community health service team - comprised of a home health nurse, a public health nurse, and a CHR, working on behalf of their communities to monitor community health conditions, to promote community health issues, and to advocate for community health interests - will have a significant impact on both the incidence and prevalence of selected illnesses and the cost of providing clinical care for these illnesses. It is the well-trained CHR, not the nurses, who is the key in this type of effort. Without this community-level expertise, knowledge of local communities, conditions, and individuals and families, we believe that effective prevention/promotion efforts would be severely hampered.

In closing, let me say that Senate Bill 400 is an important piece of proposed legislation because it establishes policy, it mandates coordination and planning, it suggests shifts in resource allocation, and it provides necessary programmatic support. We view the bill as (1) implementation guidance for pertinent sections of S.277 and H.R. 1426 when a "437" reauthorization bill becomes law and (2) as a strong message to IHS and the Reagan Administration that "business as usual" is no longer acceptable.

Mr. Chairman, members of the Committee, the title of the youth substance abuse prevention curriculum developed by the Navajo Nation is On the Right Track. Indeed, S. 400 is "on the right track." We strongly endorse your efforts to improve the health of our people.

Senator **Bingaman**. Should we go ahead to questions, or did somebody else have a statement? What is your intention here?

Ms. **Levaldo**. We could go ahead and summarize our statements, and then you can ask questions.

Senator **Bingaman**. OK. Why don't each of you just take a minute or two, if you could, and summarize what you have to say. And then, perhaps, Senator DeConcini will have a question. Go right ahead.

STATEMENT OF TONY SECATERO, PRESIDENT, CANONCITO BAND OF NAVAJOS, AND BOARD MEMBER OF THE NATIONAL INDIAN HEALTH BOARD, CANONCITO, NM

Mr. **Secatero**. Senator DeConcini and Senator Bingaman and Congressman Richardson, my name is Tony Secatero. I am president of the Canoncito Band of Navajos, and I am a representative of Albuquerque Area Indian Health Board and the National Indian Health Board. I appreciate the opportunity to express our concerns and recommendations regarding S. 400.

In the past, we have always been concerned with only treating those that are affected with a disease, alcoholism, tuberculosis, and all other aspects of health problems, social problems.

But in recent years, the last 2 years, there has been a trend changing to health promotion and disease prevention. Nationally, we have testified before various committees of Congress and expressed a concern for increase in prevention and health promotion.

In recent years, the Canoncito Band of Navajos has taken initiative in integrating a service of direct patient care with prevention. And prevention is a very vital concern of the Indian people today. It's a new pattern, a new system that we need to look at.

I think that health among the Indian people has been a major problem to a large extent. With the S. 400, we can integrate those services directly with direct patient care.

In our testimonial, we have expressed a concern for the many budgets that have been cut by the administration. We request that you support the reauthorization of the Indian health care improvement, and we hereby endorse your S. 400; however, we request that no funds be taken from the existing health programs. Thank you.

[Mr. Secatero submitted prepared statements of the Canoncito Band of Navajos and the National Indian Health Board. Testimony resumes on p. 50.]

TÓ HAJIILEEHÉ
CANONCITO BAND OF NAVAJOS

STATEMENT OF PROPOSED LEGISLATION
ON HEALTH PROMOTION AND DISEASE PREVENTION
CANONCITO BAND OF NAVAJOS
NEW MEXICO

Presented by
Tony Secatero, President

S 400

Before the
Senate Select Committee on Indian Affairs
Gallup, New Mexico

June 1, 1985

NEW MEXICO 87026 6-4221

CANONCITO BAND OF NAVAJOS

Mr. Chairman and Senate Select Committee on Indian Affairs, my name is Tony Secatero, President of the Canoncito Band of Navajos here in the State of New Mexico. I am representing the Canoncito Band of Navajos, Albuquerque Area Indian Health Board, and the National Indian Health Board. I sincerely appreciate the opportunity to present our views and recommendation on the Health Promotion and Disease Prevention Act of 1985. Although a member of the Navajo Nation Canoncito is geopgraphically separated from the main body of the Navajo Tribe. Through history Canoncito has always lagged behind in health, education and welfare. But in recent years the younger generation have expressed strong concerns to change and to begin long range planning in all aspect of community needs. Canoncito begin a long venture in hopes of improving the status of the people, many changes are now beginning to take place in health, education and welfare. Although being under the shadow of the Nvajo Tribe we have taken careful steps to be more and more self-sufficient and making every effort to make long and short range planning, many development now have taken place, health has been very dominating in respect to health promotion and prevention. We were very fortunate to get a new Health Center through the efforts of our Congressional Representative and Congressional Committee's, we feel very proud and now have intergrated many services and promoting health in all fields. In the past our only concerns were treating those that were already affected with disease of Alcoholism, Drug, Tuberculosis, Nutrition, and manySocial problems. We believe that Senate Bill 400 is a vital legislation that addressses what have been neglected in the past and would promote health and disease prevention, we feel that the Indian people are very fortunate to be considered for such legislation. With our past experience of intergrating health

Promotion and Disease Prevention on the Canoncito Reservation, this Legislation would be a Key to the changing of health service pattern into a new field of health care before being affected. We express to the Senate Select Committee on Indian Affairs that we endorse Senate Bill 400, however we request that no fundings be taken from existing programs. We fully support the formalizing and programming a policy on health promotion and disease prevention short and long term and that Indian Tribe be involved in all phase of planning activities model or demonstration projects. If we are extremely concern of health promotion and disease prevention the CHR Program has been the key vehicle in all communities as they play the front line of not only generalist, but changing of system to specialized field of Dental Assistant, Maternal and Child Health, Nutrition, Emergency Medical Services, Optometry, Social Services, Family Planning, Environmental Health, Safety as similar to the Senate Bill 400 proposed legislation. Training your own people is the most vital as they are familiar with the people by custom, language, cultural and closeness. Chairman and Senate Select Committee on Indian Affairs we are extremely concern over the Administrations proposal to reducing and eliminating very essential and effective program, we ask that you support the reauthorization of the Indian Health Care Improvement Act, because we need those service to reach the ultimate goals of improvement Indian health to that of the general population. There is a continuous need of clinical services, preventative health, urban program, manpower, Tribal Management, direct operation and health facilities. We have continuously testified before various committee's of Congression request to support reauthorization of Indian Health Improvement Act and now support Senate Bill 400 on Health Promotion and Disease Prevention.

Thank you,

PRESIDENT'S BUDGET REQUEST, FISCAL YEAR 1986
Indian Health Service
($ in thousands)

HEALTH SERVICES	APPROPRIATIONS FY 1985	PRESIDENT'S PROPOSED* FY 1986	% CHANGE
Clinical:			
Hospital & Clinics	$417,016	$418,221	+ .3%
Dental	24,923	25,215	+ 1.2%
Mental Health	11,179	11,304	+ 1.1%
Alcoholism	24,482	24,776	+ 1.2%
Maintenance & Repair	8,570	8,673	+ 1.2%
Contract Care	163,956	165,866	+ 1.2%
Subtotal, Clinical	$650,126	$654,055	+ .6%
Preventive:			
Sanitation	$ 20,275	$ 22,272	+ 9.85%
Public Health Nursing	12,212	12,195	- .14%
Health Education	3,576	3,573	- .08%
Community Health Reps.	25,480	-0-	-100.00%
Immunization	3,626	2,721	- 24.96%
Subtotal, Preventive	$ 65,169	$ 38,761	- 40.52%
Urban	$ 9,800	$ -0-	-100.00%
Manpower	$ 6,499	$ 6,499	0
Tribal Management	$ 2,450	$ -0-	-100.00%
Direct Operations	$ 59,684	$ 56,778	- 4.87
TOTAL, HEALTH SERVICES	$793,728	$756,093	- 4.74%
HEALTH FACILITIES			
Hospitals:			
New & Replacement	$ 19,843	$ -0-	-100.00%
Modernization & Repair	2,086	2,450	+ 17.44%
Subtotal, Hospitals	$ 21,926	$ 2,450	- 88.82%
Outpatient Facilities	$ 9,712	$ -0-	-100.00%
Sanitation Facilities	$ 24,500	$ -0-	-100.00%
Personnel Quarters	$ 5,493	$ -0-	-100.00%
TOTAL, HEALTH FACILITIES	$ 61,634	$ 2,450	- 96.02%
GRAND TOTAL	$855,362	$758,543	- 11.31%

* $10 million unobligated Medicaid/Medicare FY 1985 funds to be carried over and used in FY 1986.

STATEMENT ON PROPOSED LEGISLATION ON HEALTH PROMOTION AND DISEASE PREVENTION AMONG AMERICAN INDIANS AND ALASKA NATIVES

S. 400

Presented By
The National Indian Health Board

Before The
Senate Select Committee On Indian Affairs
Gallup, New Mexico

June 1, 1985

Mr. Chairman, I am Tony Secatero, the representative from the Albuquerque Area Indian Health Board to the National Indian Health Board (NIHB). On behalf of the NIHB, I wish to thank you for this opportunity to present our views with regard to the proposed legislation to formalize policy and programming for health promotion and disease prevention among American Indians and Alaska Natives.

The NIHB, a nonprofit organization based in Denver, CO, is composed of twelve representatives elected by their respective area health boards or inter-tribal organizations in each of the twelve Indian Health Service (IHS) service areas. Since NIHB's founding, we have supported and encouraged preventive health measures and health promotion among Indian people by the IHS and the tribes. More recently we have intensified this approach with the conviction that it contributes significantly to achieving the ultimate goal of raising the health care status of American Indians and Alaska Natives to the level of the general population of the United States. We, of course, continue to support the delivery of primary health care services to Indian people; however, we are convinced that prevention and health promotion is also required to ensure that the goal of parity is achieved.

The Administration has, in their testimony on the reauthorization of the Indian Health Care Improvement Act and the FY 1986 budget hearings, endorsed providing preventive and health promotion services. However, in the same testimony they have asked for reduced funding for such activities. We believe that this is inconsistent and shortsighted. In the long-run, this action would cause many of the gains made in improving the status of Indian health to be lost.

We are convinced the time has come for legislation such as S. 400 to promote preventive health and health promotion services. Not only will it help to formalize policy, but it will help to encourage what seems to be taking place in many Indian tribes and Alaska Native groups. There has been increasing activities in these areas. For example, health fairs are being conducted as a means of early detection by more and more tribes and organizations. Various forms of organized exercise activities are occurring such as "fun runs," aerobics, and walking. In spite of all the negative publicity on the problems of Indian children and youth, more and more of them are becoming involved in organized sports both in school and in organizations outside of school.

In the area of nutrition there is a growing awareness among Indian people that, regardless of age, more attention needs to be devoted to this area as a means of prevention of health problems. Programs such as Headstart, the WIC Program, Title III, and Title VI nutrition programs have quietly made a significant impact on the health status of those participating in them.

NIHB has increasingly focused its activities to support and encourage IHS and Indian and Alaska Native tribes and organizations to expand and strengthen their health promotion and disease prevention programs. Our educational and information sharing activities have included material on prevention and health promotion. The NIHB Health Reporter frequently includes articles pertaining to health health promotion and prevention. In our last three national conferences heavy emphasis was placed on health promotion and disease prevention. At these conferences, the presentors demonstrated significant interest in these areas. For example, the Sixth National Indian/Alaska Native Health Conference in Reno, Nevada last June revolved around the theme: "The Key To Prevention--YOU!" The presentations supported our observation that increased interest and activities in prevention are growing among Indian people. At this same conference, surprising attendance was experienced at the "fun run" and daily rhythmic aerobic sessions.

We plan to continue supporting health promotion and disease prevention activities in IHS and among Indian people. For example we are already encouraging Indian people to seek complete periodic health examinations as a means of health maintenance and early detection.

As we testified previously with regard to the reauthorization of the Indian Health Care Improvement Act, we strongly support retention of previous programs that made dramatic impact on reduction of morbidity and mortality rates in several disease areas. The impact has been well documented. We are dismayed that the Administration continues to recommend elimination of such obviously successful programs as construction and maintenance of sanitation and waste disposal systems, safe water supplies, and the Community Health Representative Program.

It would be unrealistic to formalize policy and increase programming for prevention and health maintenance activities with little or no resources to implement them. There is concern that funding cannot be assured for existing programs, and therefore will not be adequate and interrupted for new programs. For example, in the Administration's FY 1986 budget request, a 40.5 percent decrease was requested by the Administration in the following preventive programs: Sanitation--reduced $412,000; Public Health Nursing--$372,000; and Health Education--$115,000. One of the largest decreases would be in the Alcoholism Program where there is a suggested decrease of 1.2 million dollars which would significantly impact all services including those that are preventive in nature.

The following comments and recommendations address the provisions in the proposed legislation:

1. We fully support formalizing and programming a policy on health promotion and disease prevention as expressed in the three basic provisions of the proposed legislation: (a) development of a health promotion and disease prevention Indian health policy; (b) inclusion of health promotion and disease prevention services within the Indian Health Service; (c) continuation and improvement of the Community Health Representative Program as the mechanism to carry-out such health promotion activities; and (d) authorization of a demonstration project.
2. We support the inclusion of a specific section (204) in the Health Care Improvement Amendments of 1985 with language which is basically the same as S. 400. This will help to strengthen the policy and programming for which IHS will ultimately be responsible.
3. We endorse the provision in Section 203 of S. 400 that a study be conducted, the results of which are to be used as a bsiss for both a short-range (three year period) and a long range (ten year period) plan. It is very important that tribes be involved in this effort via their including health promotion and disease prevention plans in their tribal specific health plans. This should also not preclude tribes providing other forms of input into a national planning effort.
4. Requiring IHS to employ additional personnel to fill at least four full time positions reflects a commitment to develop and provide services as soon as possible. The main concern with this requirement is that we are against taking money from other essential programs. Additional funds to fill these four positions should be authorized and assurances should be made that monies will not be taken from other essential programs and services.
5. We support the provision to establish from one to four demonstration projects to identify the most cost effective composition of services and programs for prevention and health promotion. The only suggestion we would make is to modify the language in Section 204 of S400 to allow qualified health-related Indian organizations to compete for these grants. These Indian organizations could work in association with a health profession school, training institution, or health care institution which would be responsible for the technical aspects of the demonstration project.

This would provide another way for Indian people to be involved in planning and providing prevention and health promotion services. The authorization of $500,000 for the purpose of carrying out the demonstration projects should be an absolute minimum in order to ensure useful data from such an effort.

6. Finally, NIHB continues to strongly support retention and upgrading of the Community Health Representative Program (CHR). This role for the CHR Program, as outlined in Section 107 of S.400, not only taps the expertise of these dedicated people, but it will formalize most of what they are already doing in the field. The proposal to incorporate training for CHR personnel and other Indian people in Indian communities is highly recommended.

With regard to the FY 1986 budget for IHS and for the reauthorization of the Indian Health Care Improvement Amendments of 1985, we have stated in previous testimony that the CHR Program has been strongly supported by professional health care staff and by the people in their own communities. We also wish to point out again that the Administration's budget clarification estimates that 1,500 CHR's will provide approximately 1.96 million health care services in FY 1985 in the areas of general health care, dental health, gerontological care, maternal and child care, mental health, and environmental health certainly documents the work they do to raise the health care status of Indian people to that of the general population. We believe this legislation will help to retain the CHR Program and hopefully, funding levels for the Program will be adequate to meet their needs. This includes the 5 million dollar additional request to provide their personnel with a modest cost of living adjustment.

Finally, we wish to share with you the information that the next NIHB National Indian/Alaska Native Health Conference will be held in Albuquerque, NM, in November, 1985. The theme of this conference is "Today's Youth--Tommorrow's Elders: A Commitment to a Healthier Nation." A major focus, again, will be on prevention of disease. Senator Bingaman, because of your commitment and interest in health promotion and prevention of disease, we hereby invite you to speak at the conference.

Thank you again for allowing our testimony. If you have any questions, I am willing to address them.

Senator Bingaman. Yes, sir, did you have some testimony? Please go right ahead.

STATEMENT OF KENNETH CODY, SR., PRESIDENT, NAVAJO NATION COUNCIL ON AGING, WINDOW ROCK, AZ

Mr. Cody. Mr. Chairman, the Honorable Dennis DeConcini, Mr. Bingaman, Mr. Richardson, members of the staff, my name is Kenneth Cody, Sr. I am the president of the Navajo Nation Council on Aging. The Navajo Nation Council on Aging has elected me to testify about their concerns as related to S. 400.

First, I would like to thank Senator Jeff Bingaman and the committee for allowing the Navajo elderly to have an opportunity to speak about their concern today.

The promotion of good health and disease prevention is very important to the elderly throughout the United States. Many elderly nationwide have major health problems that require special care and attention. This is especially true for the Indian elderly.

Currently, there are about 18,000 Navajo elderly 60 years of age and older. Of these elderly, the Navajo Tribe Aging Department reaches about 6,000 individuals. This leaves about 11,000 elderly individuals throughout the Navajo Nation not receiving services including health and nutrition services.

To prevent disease and health problems from occurring, we, the elderly of the Navajo Tribe, support S. 400. We also feel that to promote better health among the elderly, a national Indian aging policy is needed.

Many Federal agencies have service programs or funds directed to the health and well-being of the Indian elderly. However, these agencies are not guided by a national Indian aging policy.

We sincerely feel that such a policy would coordinate Federal funds, improve service, and allow to Indian elderly a healthy and happy life.

We call on your support as a committee of Congress for the establishment of such a policy. In addition to these concerns I have mentioned, there are seven areas of concern that the Navajo aging staff and the Navajo Nation Council on Aging have identified. These concerns are provided in writing to the committee.

We feel that these seven areas need to be addressed by Congress to promote better health of the elderly, also. In conclusion, I want to stress that the needs of the Navajo elderly are great, but we can work together through legislation and policy development to attain better health care for all Indian elderly.

Carry this message back to Congress and join us in the Navajo blessing and prayer for the preservation of harmony, beauty, and health.

I'm going to say this in the Navajo words.

[Mr. Cody speaking in Navajo.]

Mr. Cody. Thank you.

[Mr. Cody's prepared statement, on behalf of the Navajo Nation Council on Aging, with attachment, follows:]

THE NAVAJO NA
WINDOW ROCK, NAVAJO NATION (ARIZONA) 86515

TERSON ZAH
CHAIRMAN, NAVAJO TRIBAL COUNCIL

EDWARD T. BEGAY
VICE CHAIRMAN, NAVAJO TRIBAL COUNCIL

June 1, 1985

Testimony of:

Kenneth Cody, Representing the Navajo Nation
Council on Aging, Navajo Aging Services Department
The Navajo Nation

My Name is Kenneth Cody. I am the President of the Navajo Nation Council on Aging. The Navajo Nation Council on Aging has selected me to testify about their concerns as related to Senate Bill 400.

First, I would like to thank Senator Jeff Bingaman and the Committee for allowing the Navajo elderly the opportunity to speak about their concerns today.

The promotion of good health and disease prevention is very important to the elderly throughout the United States. Many elderly nationwide have major health problems that require additional care and attention. This is especially true for the Indian elderly.

Currently, there are about 18,000 Navajo elderly 60 years of age and older. Of these elderly, the Navajo Tribe's Aging Department reaches about 6,000 individuals. This leaves about 11,000 elderly individuals throughout the Navajo Nation not receiving services, including health and nutrition services. To promote better health, and to prevent disease and health problems from occurring, we, the elderly of the Navajo Tribe, support Senate Bill 400.

We also feel that to promote better health among the elderly, a national Indian aging policy is needed. Many federal agencies have services, programs, or funds directed to the health and well-being of the Indian elderly. However, these agencies are not guided by a National Indian Aging Policy. We sincerely feel that such a policy would coordinate federal funds, improve services, and allow the Indian elderly a healthy and happy life.

We ask for your support as a committee of Congress for the establishment of such a policy.

In addition to these concerns I have mentioned, there are seven (7) areas of concern that the Navajo Aging Staff and the Navajo Nation Council on Aging have identified.

These concerns are provided in writing to the Committee. We feel that these seven areas need to be addressed by Congress to promote better health of the elderly also.

In conclusion, I want to stress that the needs of the Navajo elderly are great, but we can work together through legislation and policy development, to attain better health care for all Indian elderly. Thank You.

Testimony of Navajo Nation Aging Service Department
on Senate Bill 400
June 1, 1985

(1) Title VI of the Revised Older American's Act of 1978 was established by the Congress of the United States to allow for direct funding to recognized Indian Tribes. Currently, a federal appropriation of approximately 7.2 million dollars for over 250 eligible Indian Tribes is far less than necessary to effectively implement the provisions and intent of Title VI. A minimum appropriation level of 25 million dollars for all eligible Indian Tribes must be supported to ensure the Older American's Act will positively impact on Indian elderly throughout the United States.

(A) Due to regulatory requirements, Title VI and Title III of the Revised Older American's Act of 1978 cannot be combined to serve elderly clientel in the same remote service areas of the Navajo Nation. The Navajo Aging Services Department has been officially recognized as a Tri-State Area Agency on Aging, and although Title VI and Title III funds are received, these funds implemented separately for the same service population are not sufficient to meet the many various needs of the elderly. Within Indian nations, it would be much more effective to combine allocated funds from the same source to maximize service delivery to affected Navajo elderly.

(2) A National Indian Aging Policy was to be developed by the Administration on Aging in late 1982, as committed by the former Commissioner on Aging, Dr. Lennie Marie Toliver. However, to date, a national policy has not been developed. Currently over 50 Indian Tribes have united to develop a draft of a proposed National Indian Aging Policy, since the Administration on Aging is not moving on the policy. This draft policy, which will be presented to the Congress of the United States in the spring of 1985 is necessary to ensure that the "safety net" of services to the Indian elderly is maintained and strengthened in order to preserve and protect generations of traditional Indian elderly and fulfill trust responsibility provisions of the federal government. Many Indian elderly have been neglected in the preservation of the "safety net" guaranteed by the President of senior citizens of the United States.

(3) Public Law 95-531, the Navajo Hopi Relocation Act, has caused great physical and mental anxiety and stress for both the Navajo and Hopi elderly. Funds and services need to be developed immediately to ensure the Indian elderly affected by this law are safeguarded during the discussions and decisions between the Tribes and the federal government. These funds and services are needed in all lands occupied by both tribes, as well as new lands acquired for potential relocatees.

(4) Navajo elderly related programs continue to be effective, but limited funding has prevented the programs from reaching the minimum service levels necessary to guarantee basic human services including food, shelter, transportation, health care, and economic security. There are approximately 18,000 Navajo elderly, age 60 years and over located across the 25,000 square miles of the Navajo Nation, current services impact about 6,000 elderly Navajos.

(A) Elderly volunteer and employment programs have been widely accepted and supported by the Navajo Tribe. Currently, only Region IX (San Franciso) provides federal funding for the Navajo Nation's Foster Grandparent Program, while Region IV (New Mexico) and Region VIII (Utah) do not provide federal funding to geographic service areas and populations of the Navajo Nation within their jurisdiction. Navajo elderly living in New Mexico and Utah are counted in periodic census surveys, which in turn, is the basis for many federal allocations, yet these funds allocated by Congress are not directed toward these service populations of needy Navajo elderly.

(5) Public Law 93-638, the Indian Self-Determination and Education Assistance Act, is not being properly implemented by various sectors of the Bureau of Indian Affairs. For example, through the mandates of Public Law 93-638, the Navajo Tribe, exercising their sovereignity and government-to-government relationship with the United States, formally established a Navajo Nation eligibility criteria for elderly individuals through the recognized Navajo Tribal Council formally established Health and Human Services Committee. However, the Bureas continues to not recognized this formal tribal action, although provisions of Public Law 93-638 clearly allow tribal governments to authority to establish tribal criteria and policy to serve needy elderly in a responsive, humane way, while simultaneously conforming with the law.

(A) Public Law 93-638 distinguishes between financial assistance and service only. BIA has confused receipt of financial assistance with receipt of services. The Navajo elderly are not receiving financial assistance, but much needed services through Public Law 93-638 funds. Therefore, eligibility levels for services under Public Law 93-638 must be consistent with "the deficit between resources and money amounts necessary to meet the cost of basic items and or special items as established pursuant to the Social Security Act by the ...state in which the applicant resides" (25 CFR). This misinterpretation of the law (financial assistance as compared to service only) is adversely affecting hundreds of Navajo elderly who are not asking for welfare payments, but are simply asking for a service through Public Law 93-638.

(B) The Navajo Tribe has worked cooperatively with ACTION, the Federal Volunteer Agency, to draft a memorandum of agreement that would allow both ACTION funds and Public Law 93-638 funds to be used in combination for Senior Companion in-home care services. Such use of federal funds is in conformance with regulations contained in both 25 CFR and 45 CFR, as exemplified in 25 CFR 271.54. However, although ACTION is responsive and supportive of this interagency memorandum of agreement, the BIA has continued to withhold commitment to such an angreement, although legal mandates clearly allow coordination of federal funds fo maximum delivery of services to eligible clients.

(6) Elderly Navajo Veterans who served their country in good faith do not have established direct services for their many needs on the Navajo Nation. Veterans must travel long distances to receive beneifits guaranteed by the federal government. Many veterans do not have the economic resources and transportation needed to seek assistance they have legitimately earned through loyal and dedicated service to their country. Establishment of a home for elderly veterans on the Navajo Nation is a definite priority need that must be supported by all federal agencies responsible through a proper allocation of funds, and respect for veterans who served.

(7) Aging funds intended for Indian elderly go through several layers of bureaucracy, regional, state, and county, before getting to the target population. This results in administrative cost taking priority away from direct services, ultimately resulting in less services to the elderly, while simultaneously sustaining the bureaucracy. Establishment of an Indian Desk within the Administration on Aging and within the Office of Management and Budget to receive aging funds, and target such funds to service populations THROUGH DIRECT FUNDING to recognized Indian Tribes, has been continually requested by Tribes' throughout the Southwest. This request was made at a Congressional hearing conducted by the Committee on Interior and Insular Affairs in May, 1984 at Tucson, Arizona. Such a mechanism within OMB and the Administration on Aging would allow direct funding while simultaneously ensuring accountability and delivery of basic services to the Indian elderly.

Senator **Bingaman**. Thank you very much. Michael, did you want to testify here? We're anxious to hear your testimony.

STATEMENT OF MICHAEL LINCOLN, DIRECTOR, NAVAJO AREA INDIAN HEALTH SERVICES, WINDOW ROCK, AZ

Mr. **Lincoln**. I will be brief. Senator Bingaman, Senator DeConcini, Congressman Richardson, I would like to point out, just to supplement the testimony given by the Navajo Tribe and Ms. Levaldo, it is a little bit unusual for an Indian Health Service employee to be part of a tribal panel, and I'm appreciative of the committee's efforts to allow me to do so. And, also, I am appreciative of the Department's willingness to allow me to be part of this panel.

I think the critical part of the information that is provided both within the Indian Health Service testimony for the Navajo area, which is part of Mr. Ivey's presentation this afternoon, and the Navajo Tribe's testimony, is the changing patterns in diseases that we're seeing on Navajo.

Indeed, in 1960, over 40 percent of all deaths to Navajos were the infants under the age of 1. In 1980, 8 percent of deaths are to infants under the age of 1. The national average is 2 percent, so we're still four times the national average.

The changes in mortality patterns for the same period of time are as follows: In 1960, the leading cause of death to Navajos was accidents. That, indeed, has not changed in 1980.

Second leading cause of death was influenza, accounting for 12 percent of all deaths. The third leading cause of death were diseases of early infancy.

The fourth leading cause of death were gastritis and other diseases like this, which are infectious diseases.

The fifth leading cause of death were diseases of the heart. This was in 1960.

In 1980, the leading cause of deaths remains accidents. The second leading cause of death is other accidents; automobile accidents being the first leading cause of death and then other accidents. This accounts for in excess of 31 percent of all deaths on Navajo in 1980.

The third leading cause of death is now heart disease. The fourth leading cause of death is cancer. The fifth leading cause of death are deaths that are ill-defined, which is a catchall category.

The point that I wish to make is and to reinforce what Ms. Levaldo has said, is that those changes in mortality and like changes in morbidity patterns have moved from the infectious, communicable diseases to chronic diseases.

However, there is still a significant workload in the Navajo area associated with infectious and communicable diseases.

Now, our clinics are still busy seeing kids that have influenza and pneumonia and other similar types of diseases.

I would like to point out that there is an equally significant factor that is not included in the data that I just mentioned, and that is the population distribution of Navajo, and I believe, of Indian country.

On Navajo, over 50 percent of our population of 161,000 people is under the age of 17 years. What that means is that there are

80,000 young Navajo people that are going to exhibit behaviors that are going to drive the health service that we're currently providing.

Some of these behaviors are going to be obviously related to automobile accidents. We anticipate that automobile accidents is going to remain very high and that we must start intervening at an early stage in this tragedy.

Also, that, indeed, on Navajo last year, there were 4,300 births. Throughout the Indian Health Service, there were approximately 5,500 births of Navajo babies for the entire year.

An active maternal and child health program that has the preventive health component that is embodied in your piece of proposed legislation will be absolutely critical in improving the health status of Navajos down the road and over the next 20 or 40 years.

I would like to point out that in our testimony that is included in Mr. Ivey's statement to you that we have identified what we consider to be a minimal preventive health effort for the Navajo area. It is broken out by age group, under 4 years; the middle teens; and then major problems for the elderly. The 25- to 65-year-old group in terms of diabetes, hypertension, specific efforts that the Navajo area will undertake for the over 55-year-old group especially regarding immunizations for influenza, pneumonia, and other types of diseases.

In conclusion, what I would like to emphasize that I think is a critical part of S. 400 is the aspect of a partnership that needs to be developed. This partnership on Navajo has started between the Navajo Tribe, its various divisions, and in particular, its division of health and the Navajo area.

But there are also other providers of health care on the reservation that need to be included in this partnership. In addition, certainly, the State health departments, since they are very active through the Block Grant Program in disease prevention, somehow have to be brought in and made a partner if we are really to address some of the health problems, from a preventive stance, on Navajo.

We hope that that part of your bill is further emphasized, and we think that there will be a significant payoff in the future. Thank you.

Senator BINGAMAN. Thank you very much. Senator DeConcini, do you have some questions?

Senator DECONCINI. Mr. Chairman, thank you, I do have. In your testimony, you speak of a need for a policy which supports the application of prevention and promotion standards established by the Government to the health status of native Americans.

Are the standards to which you're referring to—maybe you can respond to this—are the standards that you refer to already set, or would they need to be proposed and adopted, and do you have any suggestions as to what standards that you could give us, perhaps, later if you don't have them right there?

Ms. LEVALDO. As far as policies, the division of health of the Navajo Tribe, this past 1½ years, has been developing policies within the tribe itself on the types of issues that we want to see as priorities.

And health promotion and disease prevention is one of our top priorities. We have named it as a priority, and it has been validated through our own tribal committees. But on a nationwide basis, I do believe that this is one of the first nationwide efforts as far as really getting into the health promotion and disease prevention arena.

Senator **DeConcini**. And standards?

Ms. **Levaldo**. And standards, also.

Senator **DeConcini**. Have you developed any standards yourself that you might submit to us as some idea of what someone who has been involved in it might consider for standards? I'd like to see what they might be if you have developed any, if you have them.

Ms. **Levaldo**. We are just now working on them. We are trying to standardize many of our activities within the division. We can submit what we have to you at a later date.

Senator **DeConcini**. Fine, thank you. Thank you.

Senator **Bingaman**. Congressman Richardson, do you have some questions?

Representative **Richardson**. Thank you, Senator. I have one question and just one brief statement to make. S. 400, Senator Bingaman's bill, has 14 objectives, 5 in the area of health promotion, and 9 in the area of disease prevention. And I am going to ask you a very tough question because it's mostly going to be a question related to priorities based on budgetary needs and budgetary availability.

And I know Mr. Lincoln mentioned the tremendous tragedies in many of these areas and the importance of focusing on where the critical needs are. But I'm just going to read these to you, and, perhaps, if you had three of these to give the utmost priority to in the areas of health promotion and disease prevention, if you could tell us, I think that would be extremely useful.

In health promotion, the five would be cessation of tobacco smoking; two, reduction in the misuse of alcohol and drugs; three, improvement of nutrition; four, improvement in physical fitness; five, control of stress.

In the disease prevention area the first would be immunization, two would be control of high blood pressure, three would be control of sexually transmittable diseases, four would be family planning, five would be pregnancy and infant care, six would be control of toxic agents, seven would be occupational safety and health, eight would be control of accidental injuries and nine, clorination of water.

And I guess my question is, if you had three of those to focus most of our attention on, given the budgetary limits that we have, and I'm relating to the Navajo Nation right now because we do have representatives in yourselves, which would those three be in your judgment?

And I will give you page 2 of Senator Bingaman's bill.

Ms. **Levaldo**. I would have to say alcohol is the top priority. Accidents, also, are another priority, primarily motor vehicle accidents. But the majority of the problems on the Navajo are related to alcohol, as accidents, disease, family problems, and behavioral health problems.

Also, nutrition would be another area of priority. We do have, within the division of health, a major department, the food and nutrition department, under which we have a Community Nutrition Education Program which has, as its primary goal, to educate the Navajo people on nutrition.

This is because over the years our diet has changed. There are many new types of foods, and in a lot of ways, we have to kind of go back to the old Navajo ways as far as eating the more healthy foods from plants and the things that we grow as opposed to processed fast food.

There is also a great need to focus on control of stress. So I would say that that is also a major priority, which is also related to the misuse of alcohol and drugs.

We do have programs within the Navajo that do address many of the other areas, as family planning, sexually transmitted disease, and CHR's do focus on high blood pressure.

So as for major areas, I would say these would be alcohol, nutrition, and control of stress. The others on the panel can also react.

Representative **Richardson**. I just want to capsulize what you said and commend you because I agree with you 100 percent, especially alcoholism, which I think is the biggest killer of them all among the Navajo people.

I have a statistic that my staff provided me with that 62 percent of all deaths in the Navajo Nation are alcoholism-related. And in this connection, I want to ask for your support and this community's support for an initiative in a House bill that would provide for a $1.2 million demonstration project right here in the Gallup area at the Rehoboth-McKinley Facilities Friendship Hospital, a cooperative effort between the IHS and the Navajo Tribe and some of the local community that would deal exactly with Senator Bingaman's approach, the preventive aspect of alcoholism, residential services, many rehabilitation approaches, new approaches that are being tried in alcoholism, because I think, quite frankly, in this area that is so critical, we have all failed.

And I think it's going to take a community effort to try some new approaches, and I think this is why Senator Bingaman's bill is so important.

That provision in the House bill has passed both House committees. I take occasion here to lobby my colleagues in the Senate so we get that in the Senate, too.

But I think it is a new initiative, a good initiative, and I appreciate the cooperation that we have received from your office and your recognition of the three most important needs. And I am so delighted that you've narrowed it down to that way. And from our part, I know we will do everything we can. But the credit should be to my colleague from New Mexico, Jeff Bingaman, for, in a major policy statement, focusing on what the objectives of health care of the Indian nations would be. Thank you.

Senator **Bingaman**. Thank you very much. Let me just ask a question, and then we'll go on to the next panel.

Your testimony, Michael, particularly yours, has concentrated on the statistics demonstrating how much of the Navajo population is very young.

And the issue of health care in the future is so dependent upon the habits and knowledge that this young population receives early on. Later we're going to be having a panel on education and the part that education in the elementary schools and secondary schools can play in promoting health habits. Is that something that you think the Indian Health Service or the Navajo Nation needs to take a stronger part in? Is that something where we're completely dropping the ball?

I guess my impression is that is an area where we are completely dropping the ball, let me say that. And if you disagree, I would be interested in hearing it.

Mr. LINCOLN. I certainly don't disagree. I believe that one of those partners that we haven't developed to the extent that we should has to be the local school systems.

And I hope that what I say isn't misinterpreted, but we do have a captive audience. We have a group of people that are at high risk for a number of problems, and they are school age people.

In part of our testimony that is included in Mr. Ivey's document, the Indian Health Service document, we identify that relationships should be developed with the various school systems and the school boards especially in health education with a health education emphasis for motor vehicle accidents for some—just some general awareness and good solid health education on alcoholism, nutrition, as it relates to obesity.

And I will read a specific statement. Up to 65 years of age, we believe obesity is going to be one of the major contributors to significant health problems for Navajos in the future. It is a little ironic that I would be the one talking about this. And I'm going to have to do something about this, also.

But nutrition education and exercise program need to be developed to reduce hypertension and other cardiovascular complications for this age group and for this problem. And we believe, as the statement says, that we are going to have to work with school boards, we are going to have to work with teachers, we're going to have to develop a reservation-wide strategy and program specifically focused at young people.

Not that we are trying to ignore the other age groups, it is just that those behaviors need to be developed early. They need to be sustained over a long period of time, and we think if the preventive health efforts will be focused on the younger group, we may prevent some of the problems and sequelae that affect people at a later stage.

Senator BINGAMAN. OK. Thank you very much, and I appreciate the testimony from all of the members of this panel. We are at the end of the first panel and already running behind, so why don't we go right ahead.

The next panel—we're going to really combine a couple of the panels we intended here. Gilbert Peña, who is the chairman of the All Indian Pueblo Council in Albuquerque, is going to head this off. And other members are Alvino Lucero, governor of the Isleta Pueblos; Anthony Yepa, who is the health services administrator for the Five Sandoval Pueblos; Frances Chavez, chairperson of the health advisory committee of the Sandia Pueblo; Tom Lujan, who is the substance abuse inpatient treatment and prevention project chair with the Eight Northern Indian Pueblo Council; Bruce Leonard of Zuni; and Larry Curley of Laguna.

If all of you could come up, please, and take a chair. We'll have to just pass the microphones around.

Now, Gilbert, we would appreciate it if you would start off. And as I indicated, we're already running behind. If you could do whatever possible to summarize the testimony as you go through it, that would be a great help to us, and we'll still have some time for questions from the Congressman and the Senator.

STATEMENT OF GILBERT PEÑA, CHAIRMAN, ALL INDIAN PUEBLO COUNCIL, ALBUQUERQUE, NM

Mr. PEÑA. Thank you, Senator Bingaman. Senator DeConcini, Congressman Richardson, it is good to see all of you here again today. And, Mr. Chairman, thank you for giving this opportunity to appear before the Senate Select Committee of Indian Affairs to testify for the great need for wellness programs on our various reservations.

S. 400, the Indian Health Promotion and Disease Prevention Act of 1985, introduced by Senator Bingaman restates the position that our leaders have been very adamant about for years.

May I profess that while primary health care is certainly a critical element in maintaining Indian health, so, also, is the need for—the need to develop and continue prevention programs which relate directly to the long-term wellness of our people.

Senator and Mr. Chairman, I think one of the most important things that has always been a high priority for us, and it is a program that is continuously, on a year-to-year basis, being phased out or proposed to be phased out or proposed to be phased out, and that is a CHR Program.

In almost every pueblo that I know of, the CHR's or the representatives in those programs are the first responders in emergency situations. They provide health care to the elderly in their respective homes. And I think they take on a variety of various programs.

And what I would like to recommend to the committee is that the CHR Program be continually funded if not become a permanent part of Indian Health Service authorization and appropriations. And in many cases, the CHR are—on the one end, they provide the type of care that I just mentioned. And in many cases, they are also the coordinators for rabies vaccination clinics in our respective reservations, so I think that it's important that we take a very strong look at the program and the effect that it has had on our various reservations.

That is, of course, a very high priority in the area of prevention. Alcoholism is another one. I think there is no doubt, and it's no secret that that is, perhaps, one of the greatest killers in our respective reservations, Mr. Chairman.

With that, I would like to, perhaps, you know, just turn it over to the Governor and the rest of the representatives here who work directly with the various health programs and let them go over some of their concerns because they work directly with the programs themselves. Thank you, sir.

[Mr. Peña's prepared statement follows:]

STATEMENT BY GILBERT PEÑA, CHAIRMAN
ALL INDIAN PUEBLO COUNCIL

S. 400 INDIAN HEALTH PROMOTION AND DISEASE PREVENTION ACT OF 1985

SENATE SELECT COMMITTEE ON INDIAN AFFAIRS

JUNE 01, 1985

MR. CHAIRMAN, thank you for giving me the opportunity to appear before the Senate Select Committee on Indian Affairs to testify to the great need for "wellness" programs within our pueblo communities and the tremendous impact which prevention programs have had in our area.

S. 400 the Indian Health Promotion and Disease Prevention Act of 1985 introduced by Senator Jeff Bingaman restates the position that our leaders have been very adamant about for years. They have professed that while primary health care is certainly a critical element in maintaining Indian health, so also is the need to develop and continue prevention programs which relate directly to the long-tern "wellness" of our people. With me today are a panel of Governors and program directors who are well prepared to relate to the committee the very special need for prevention activities in our communities. These people and their efforts represent a commitment to improving the quality of life for our Indian people.

I would like to address a number of areas today for your consideration. The common thread tying all of the prevention efforts together is the fact that prevention programs are a priority that must not be targeted for cutback nor elimination year after year. My intention, therefore, is to;

1. Underscore to the committee the importance which the pueblo people place on the valuable services provided by the COMMUNITY HEALTH REPRESENTATIVE Programs.

2. State the need for ACCIDENT PREVENTION PROGRAMS in out communities.

3. Encourage the committee to continue funding the current efforts and promote PREVENTION AS AN IHS PRIORITY.

4. Introduce a number of OUTSTANDING PREVENTION PROGRAMS that service our area which we really cannot afford to lose.

1. COMMUNITY HEALTH REPRESENTATIVE AND EMERGENCY MEDICAL SERVICES

The vast geographical areas, the rural nature of most Indian communities, and the inaccessibility of many existing and centrally located I.H.S. clinics and hospitals, have all contributed to the viability and importance of the CHR and EMS programs. The discontinuation of such services, would constitute a severe blow to the Indian communities' ability to provide preventive emergency, outreach and home-health care.

Since the CHR Program has been in existence, they have provided an enormous amount of Health Care Delivery.

Home Visits: The CHR's through home visits were able to bring out those elderly who have not been to a doctor in years. Currently home visits are made to those recently discharged from the hospital new mothers, those with chronic illness, such as Hypertension, to check their blood pressure, Diabetes, etc.

Health Education: Health Education programs are provided to the community members to increase awareness for preventive and health promotion measures,. The CHR's work with staff from the PHS, the State and other resource agencies.

Topics presented to the tribal members are dental, hypertension, diabetes, wellness, MCH, health screening, safety programs, growth & development, etc.

Public Health Nursing: The CHR's work closely with the Community Health Nurse in making home visits. Referrals are made to PHN if necessary for those who need further evaluation, screening, follow-up care, education and interpretation if needed.

Dental & Optometry: The CHR Program provides services in the area of Dental & Optometry. Appointments are made for those in need, eye glasses adjustments are done and provide dental maintenance upkeep on a quarterly basis.

Immunization: A mini-clinic for immunization is held quarterly to update immunization from infant to preschool. Currently the children are all up-to-date with their shots.

Elderly: Home visits are made to the elderly to monitor their medication, provide bedside care when needed, follow-up care upon discharge form hospital, take vital signs when necessary.

Assist the elderly with medicaid/medicare program.

Upon hospital visits to elderly, the CHR's assists the hospital staff for interpretation and translation.

For prevention and health maintenance, educational session are provided, such as exercising conductive to the elderly to participate in the Senior Citizens Nutrition Program.

ACCIDENT PREVENTION PROGRAMS

A survey of data supplied by both the Indian Health Service and the State of New Mexico indicates that unintentional injuries, which occur in the seemingly safe confines in and around the pueblo communities, account for a significant rise in the rates of death and disability. A recent publication entitled "The Injury Fact Book" claims that injury rates among the Native American population both in New Mexico and in the country are the highest for any racial or ethnic group in the country. Further evidence of this comes from the New Mexico Vital Statistics Report which states that death from accidents is higher than expected for all ethnic groups in the State. The level for the Indian population is almost four times the national average and this further accounts for about 25% of Indian deaths.

The most obvious and vicious threat to the lives and well-being of our pueblo people is the damage brought on by alcoholism related destruction. Alcohol is a contributing factor in most of the motor vehicle accidents in our communities. Many of the costly hospital admissions are in some way connected with alcohol abuse.

However, in terms of the substantial cost of primary care and the strain on this nation's budget, economic cost is really nothing compared to the social cost to the Tribe. An extremely important part of Indian culture and tradition lies in the sharing of experience and wisdom between the elders and the young people. Given the tragic rates of accidents and death among the younger age groups it is easy to see how the social order is severely impacted. Many promising young Indian leaders are now a part of the statistics.

There are currently several prevention activities in our communities which have direct impact on improving motor vehicle related injury.

Both the Indian Health Service and the State have worked with tribes in establishing Infant Car Seat loaner programs. This combined with more aggressive seat held campaigns will enhance passenger safety. However, efforts need to be further directed to the unique needs of each pueblo. We need to develop prevention activities which deal with the pick-up truck as a form of transportation. Most pueblo families own a pick-up and current prevention information deal with front seat and back seat safety.

3. Promote PREVENTION AS AN IHS PRIORITY

The major aspects of S. 400 are worthy of note:

1. Develop National Policy for Health Promotion within IHS.

2. Develop Comprehensive and long term plan of tribal and national health promotion and disease prevention goals.

3. Upgrade and improve the CHR program as the main vehicle for disease prevention services.

4. Promote demonstration projects which provide solid evidence of the effectiveness of prevention activities.

The I.H.S. in general and the Area Office in particular have formally stated their intention of emphasizing prevention activities as a matter of practice. A number of departments have followed this lead and have incorporated projects toward this end. However, when push comes to shove, prevention activities seem to be the first to go. A national policy for health promotion must be backed by commitment. The example of the CHR program is important. Every year it takes an outcry of the people to reinstate the CHR program prevention programs are first the chopping block even though prevention programs a proclaimed a priority. We want to see these programs as a basic and stable part of health services to our Indian people.

Senator BINGAMAN. Thank you. Governor, we are looking forward to your testimony.

STATEMENT OF HON. ALVINO LUCERO, GOVERNOR, ISLETA PUEBLO, ISLETA, NM, ACCOMPANIED BY JOSEPHINE JARAMILLO, COMMUNITY HEALTH REPRESENTATIVE DIRECTOR

Governor LUCERO. Thank you very much, Senator Bingaman, Senator DeConcini, and Congressman Richardson. I thank you very much for giving me the opportunity to testify before the Senate Committee on Indian Affairs in support of Indian health care of 1985.

I would also like to introduce Mrs. Josephine Jaramillo, who is the community health representative director of Isleta Pueblo.

I wish to commend you and thank you for your concern for the health promotion and disease prevention. For too many years, the Indian people have been receiving health care designed to care or treat sickness rather than to prevent sickness.

It is time to change the focus of health care from treatment to prevention. Isleta Community Health Representative, a preventative health program, offers more promise than any other approach to slow runaway cost increase in health care.

If the administration plans to eliminate the Community Health Representative Program, the long-term result will be increased costs for individual families and ultimately the Federal Government.

Mr. Chairman and members of the committee, as governor of Isleta Pueblo, along with Isleta Tribal Council, we fully support S. 400 as we can see the many benefits that will be realized by the Indian people.

Unless we educate our Indian people of the many diseases that attribute to death, the Indian people will always have a higher death rate than the national average of non-Indians.

S. 400 addresses all of the high-risk diseases and preventative-type measures, and we are fully supportive of S. 400.

The community health representatives are knowledgeable in their physical assessment skills during home visits. They provide the only local emergency technician ambulance service, interpret information in the particular Indian language, teach a wide variety of preventative health care—health programs.

They assist in school health screening, provide certain ideology and optometry services. Yet funding for the Community Health Representative Program has been eliminated.

With elimination of the Community Health Representative Program, thousands of services will no longer be available. The community health representatives are the key people to work with elderly people in schools, in clinics, in homes and hospitals and provide health education projects on health promotion and disease prevention to the Isleta community.

One preventive health project is the Isleta Annual Health Fair. Because of projects such as the Isleta Health Fair, the health knowledge and attitudes of Isleta people have changed. This change is directly attributable to skills, knowledge and abilities of the community health representatives.

Since time is limited, only the highlights of October 1, 1984, through April 30, 1985, of the Community Health Representative Program will be presented at this time. However, the written documents have been given to each of you to review at your discretion.

With this, Mr. Chairman and Senator, we have prepared all the statistics, and we have written them down so that you and the committee can review them and will know and understand exactly what the CHR Program does, not only for the Pueblo Isleta, but for other respective communities, also.

And as the chairman has indicated to you, the CHR Programs are the people that work directly with the people in these respective pueblos. We provide the ambulance emergency care to them, the communities, talking to people and telling them of the many, many health facilities, health care available to them.

And with this, Senator, we would again reiterate, as the chairman has said to you this morning, that the CHR Program should be made a permanent part of the Indian Health Programs because if we were to lose this program, many of our people would not be able to be receiving health care, which, as we have said in our testimony, we are trying to educate our people in the preventive type of health care.

And that's what we are trying to promote. And, again, alcoholism is another one of our main killers, and that's another program that we have in the Pueblo Isleta. And we certainly hope that that program will also continue.

Thank you very much, Senator.

[Governor Lucero's prepared statement follows. Text resumes on p. 91.]

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PREPARED STATEMENT OF GOVERNOR ALVINO LUCERO OF ISLETA PUEBLO, ISLETA, NM, ON

INDIAN HEALTH PROMOTION AND DISEASE PREVENTION THE COMMUNITY HEALTH REPRESENTATIVE INVOLVEMENT

DISCRIPTIVE DATA:

The Pueblo of Isleta Indian Reservation lies mainly in Bernalillo County, with a small portion in neighboring Valencia County. The main Pueblo of Isleta Village is located approximately fifteen miles south of downtown Albuquerque on the west bank of the Rio Grande.

The center of all governmental and business functions are in the main village. In addition to the main village, several small farming communities lie on both sides of the Rio Grande, with the community of Chical, in the east side of the river, the most prominent.

The Isleta Health Clinic is operated by the Albuquerque Area Indian Health Service and is under the direction of the Albuquerque Service Unit. The clinic serves tribal members and their dependents of the Isleta Reservation, plus a few other Indians who reside in communities north and south of the reservation.

The Pueblo of Isleta has a current Tribal Population of 3,454 people with 1,696 males and 1,758 females. The population breakdown by age group is shown. Table I: Population by age groups, Isleta 1984.

0-4	5-9	10-14	15-24	25-44	45-64	65+
322	268	318	760	995	461	219

The majority of the Isleta Pueblo population resides on the reservation, with approximately ten percent of the population living off the reservation.

Of the total labor force of 1108, 50 percent are employed, mostly in Albuquerque. Although Isleta Pueblo is still largely a farming community, fewer tribal members are dependent on farming for their livelihood. Of the Tribal members employed, 75.5 percent have annual earnings of over $7,000. This largely due to the proximity of Isleta Pueblo to Albuquerque and the job market.

EDUCATION

According to the 1980 U.S. Census figures, school enrollment at Isleta was as follows: 55.9 percent of 3 and 4 year olds were enrolled in nursery school, 89.5 percent of 5 to 13 year olds enrolled in elementary school, 66.3 percent of those 14 to 18 years of age were enrolled in high school, 14.8 percent of those 16 to 19 years of age were not high school graduates and were not enrolled in school. Percentages of those enrolled in college is difficult to state because there is no clearly delineated age group. 64.8 percent of those over 25 years old have completed high school and 3.5 percent have completed four or more years of college.

School facilities on the reservation include a Headstart and a Bureau of Indian Affairs Elementary for grades K-6. Parents have the option of enrolling their children in public schools in Los Lunas or Albuquerque or in private schools of their choice.

MANAGEMENT SYSTEM

The management of the Isleta Pueblo Community Health Representative Program is identifiable in three intricate parts:

1. Tribal

   The Pueblo of Isleta Tribal Council initiates and negotiates contractual proceedings. The Pueblo of Isleta Governor is authorized by the Constitution to sign off on all legal documents. The intent of the Community Health Representative is to provide and promote health services reflecting the interests and well-being of the Isleta people.

2. Service Unit/Area Office

   The Albuquerque Service Unit Director has been delegated the authority to monitor, through the Indian Health Service Project Officer, the Community Health Representative contract on behalf of the Indian Health Service. To assure that the Community Health Representative Program is in compliance with contracted services and requirements, the Service Unit Director shall maintain an awareness of all programmatic activities. The Indian Health Service Project Officer shall provide technical assistance in the area of program planning, program direction, and program coordination.

3. Health Service Administration

   The Isleta Pueblo Community Health Representative Program is a part of the health service administration and consists of a Community Health Representative Supervisor and a Secretary/Bookkeeper which oversees the daily operation and administration of the Community Health Representative Program.

MORBIDITY RATES

The ten leading causes for obtaining ambulatory patient care at clinics in 1984 were compiled for Isleta residents by the Indian Health Service Information Management Office. The rankings are listed below.

Rank	Clinical Impression	Number of Visits
1	Respiratory Diseases Upper Respiratory Infection Pharyngitis	1946
2	Endocrine, Nutritional, and Metabolic Diabetes Obesity	1176
3	Eye Disease Refractive error Conjunctivitis	1035
4	Diseases of the Circulatory System Hypertension Congestive Health Failure	1027
5	Skin Diseases Impetigo Infected Wounds	1001
6	Injuries	653
7	Ear Diseases	692
8	Pregnancy and Childbirth	467
9	Symptoms and Ill Defined Conditions	398
10	Infectious and Parasitic	298

Chronic Diseases

There are several chronic diseases which affect the people of Isleta, although many are of concern, just certain ones will be considered

HEART DISEASE

Heart disease at Isleta contributed 10.3 percent of the

HEART DISEASE, Cont'd

total deaths occurring, but only one-half of one percent of the years of life lost due to early death. The rate for Isletans from heart disease is lower than that for New Mexico and the United States. The major risk factor of Isletans for developing heart disease is obesity. The occurrance of this risk factor is very low at Isleta. The only formal data on incidence of smoking is from the health fair. None of the participants at the health fair smoked and key informants mentioned that very few Pueblo Indian in general smoke.

HYPERTENSION

Hypertension is another problem related to obesity, diet and stress. It shows a high prevalence rate for Isletans but a rather low incidence rate. This may indicate that once diagnosed, hypertensive patients tend to keep regular clinic appointments for blood pressure and medication checks. One of the Community Health Representatives is charged with providing early detection screenings at Isleta. Other residents are likely to have their blood pressure checked when attending the clinic for other reasons. The major gap in providing services for hypertensives at Isleta is in the area of prevention.

CEREBROVASCULAR DISEASE

Cerebrovascular disease is also related to the risk factors of obesity, diet, and hypertension. It contributed to 3.45 percent of the deaths at Isleta for 1981 and 1983 combined. The mortality rate from CVD at Isleta was lower than for both New Mexico and the United States. It accounted for 3.4 percent of the years lost due to early death at Isleta. The major health care gap for CVD at Isleta is prevention.

ALCOHOLISM

Alcoholism presents a complex problem for analysis with many components. It is difficult to gain an accurate estimate of the extent to which alcoholism exists at Isleta. Incidence and prevalence rates at the clinic are both low. The mortality rate for chronic cirrhosis of the liver is probably higher than both New Mexico and the United States rates, although, it is hard to say because of the small number of deaths being studied. The proportion of Isleta's deaths due to cirrhosis for 1981 and 1983 was 3.45 percent. For New Mexico it was 2.06 percent. It's contribution to years of life lost was 3.4 percent. But cirrhosis is only one manifestation of the problem of alcoholism.

ALCOHOLISM, Cont'd

Alcoholism is almost certainly a risk factor for motor vehicle accidents, homicide, domestic violence and possibly suicide. When considered in this way, the potential magnitude of the problem is very great.

Risk factors for developing alcoholism include, coming from an alcoholic family and acculturative and other types of stress.

The Isleta Alcoholism Program provides maintenance services for those with a known problem who are willing to participate. Although they have evidenced willingness and the ability to provide preventive services, they are no longer able to do so because of funding source regulations. Another gap in services for alcoholism is the lack of facilities in which to place Isletans for detoxification and in-house rehabilitation.

DIABETES

It has been estimated that type II Diabetes may be present in as many as 33 percent of the adult population at Isleta. The proportion of deaths attributable to diabetes at Isleta is 3.45 percent and it contributed only 1.67 percent of the years of life lost due to early death. The prevelence rate based on number of visits show diabetes to be the second most frequent reason for visiting the clinic. However, the incidence rates are low. This indicates that one gap is providing care to diabetics through early detection. It has been noted that the major factor indicated in the etiology of diabetes among Indians is obesity and that 55 percent of the diabetes present could be controlled through diet and exercise. Stress may be another contributing factor therefore, diabetes may be considered amenable to prevention through proper nutrition, adequate exercise, and stress control measures. One aerobic program is already in place for health promotion at Isleta through the Community Health Representative Program. This class is available for anyone interested in control of obesity and better health.

NEOPLASMS

Even though neoplasms are ranked number 17, according to 1984 incidence rates for Isleta residents, it remains a serious health problem for this population. The PMR was 20.9 compared to southern pueblos 16.1, and New Mexico, 19. 18. Mortality rates for malignant neoplasms were significantly lower in 1983 with Isleta's being 58.5, southern

NEOPLASMS, Cont'd

pueblos 45.15, New Mexico's 136.5, and the United States 188.3. However, these mortality rates are inaccurate representations of the problem since they are taken only from one year, and that the number of deaths to the population base is so low. Taking a range of years would establish more validity in the figures, and would prove more valuable in the figures, and would prove more valuable in interpretation.

An interview with a staff person at New Mexico Tumor Registry provided some valuable data in interpreting incidence rates. Since most of the incidence rates for cancer are disignated as types of cancer such as the leukemias, multiple myeloma, and other non-tumor type cancers. Also, since both Hispanics and Native Americans in New Mexico have a low incidence and mortality rate for cancer; this brings the total New Mexico figures down considerably. Instead of comparing Isleta to all of New Mexico, it was recommended to compare to New Mexico anglos for all of the United States.

The New Mexico Tumor Registry records all cancer incidences by incidence rates and mortality, breaking down the different types of cancers by age, sex, and race.

From their statistics, it is shown that New Mexico Native Americans are at a lower risk for some types of cancer and higher for others. It is also shown that Native Americans are catching up with Anglos in their incidence of cancer. This has far-reaching implications for preventive measures and for further research into the reasons why this is happening.

New Mexcio Native Americans according to a 1973-1977 study by the tumor registry, have lower incidence of lung, colon, and rectal cancer, however a much higher incidence of gallbladder and stomach cancer. This could imply that dietary habits may be contributing to the increase of these diseases, however, more research needs to be done. Lung cancer is reduced since the Indian population has a much less incidence of cigarette smoking in their population, as research has supported. New Mexico Indian females are at 12 times the risk for gallbladder cancer as New Mexico anglo females.

According to this study, comparison of incidence rates of Isleta Pueblo (1983) of .434 for all ages to the New Mexico Anglo from (1973-1977) of .345, reveals a slightly higher incidence, however the difference is not significant statistically; it does show that the incidence rate at Isleta is about the same and not significantly lower from other populations, as believed by many. The United States incidence rate according to the same study is .288. Again the years could make a difference.

NEOPLASMS, Cont'd

The top four cancers of both female and male New Mexico Native Americans and of male and female Anglo population was also taken from this report and are listed.

Incidence rates /100,000

	New Mexico Native American/ I.R.	N. M. Anglo/ I.R.
Male	1. Prostate / 47.0	1. Lung / 78.9
	2. Stomach / 30.9	2. Prostate / 77.
	3. Lung / 10.8	3. Colon / 31.
	4. Colon / 7.8	4. Baldder / 26.2
Female	1. Gallbladder / 22.3	1. Breast / 92.7
	2. Breast / 21.2	2. Uterine / 28.
	3. Cervical / 19.9	3. Lung / 24.6
	4. Pancreatic / 13.0	4. Ovarian / 14.3

These figures indicant a totally different focus on cancer and preventive measures for natives vs. non-Indians.

This data indicates a need for improved wormen's health care, eg. - stressing PAPs' to reduce cervical cancer and self breast exams to reduce breast cancer. It also indicates that possibly diet and obesity could be risk factors in the increase incidence of gallbladder cancer. More emphasis needs to be placed on nutrition and physical fitness. For men, it indicates more education on smoking and diet.

FEMALE GENITALIA

The 1983 age specific incidence rates for female genitalia rank #1 in the age 25-44, #3 in ages 15-24, and #4 in ages 45-64. This data, along with the above data relating to increased risks of breast and cervical cancer; indicate more emphasis needs to be placed on women's health care.

The PHS clinic does hold PAP clinics and OB-GYN clinics weekly, however, they are not staffed with a gynecologist or nurse practitioner. There is no women's health facility in the USPHS, Albuquerque Service Unit. Women can see a gynecologist under contract care if referred appropriately. More emphasis also needs to be placed on getting the women in for their PAPs' on a routine basis. Health teaching related to women's health needs could also be improved to reduce the risk factors.

A data collection was taken during the Isleta Health Fair on suggestions for Preventive Programs needed in Isleta, including the following;

1. Family planning

2. Drug and alcohol abuse
3. Dental hygiene
4. More exercise
5. Crisis intervention
6. Stress management
7. Early detection of cancer
8. Personal hygiene
9. Safety hazards
10. Care of the aged

88 percent felt the Indian Health Services were satisfactory Suggestions for improvement included primarily expanded clinic hours 47 percent were satisfied with contract health services. 44 percent were not and suggested in general the need for more services.

It was felt that the survey provided a form of consensus reaching among the sample population about the needs of the community based on the desires of its residents. It is recognized however that the sample obtained does not represent the entire community.

The problems of obesity, diabetes, heart disease, hypertension, and cerebrovascular disease can be analyzed as a complex of related diseases. The link is the major risk factor of obesity for all the others.

The etiology of obesity among Indian populations probably lies in the high levels of refined carbohydrates consumed on a daily basis and in the frequency of celebrating which involves consuming high calorie meals. Other contributing factors are low levels of exercise and high stress levels which may contribute to overeating.

From the assessment data it is difficult to estimate the percentage of the population which is actually obese. 55 percent of those screened at the health fair were obese but only 29 were screened. The incidence and prevalence rates for obesity based on number of clinic visits are low indicating that if the actual extent of the problem is closer to the 55 percent obtained at the health fair, the people are not seeking medical attention for the problem. This indicates that a gap in the existing health care system exits as far as providing a solution for the problem of obesity. A community awareness and prevention focus is probably the most effective means of solving the problem.

The Community Health Representative and Diabetes Team has goals of coordinating with WIC, Headstart, and the school system to identify overweight children, and for the Community Health Representative Program and Indian Health Service to develop resources to support improved nutrition and physical fitness for these children. Institution of programs to accomplish this goal would constitute a measure to reduce an identified health care gap for Isletans.

PRIORITIZATION OF PROBLEMS

1. Because the magnitude of life lost through motor vehicle accidents is great, motor vehicle accidents were chosen as a top priority for Isleta Pueblo. Years of lives lost for 1981 and 1983 were 201 years. or 36% of total years of lives lost from all problems. The majority of lives lost occured at the 15-24 year age range. By providing such as defensive driving programs relating to automobile safety and driving such as defensive driving programs, etc., they may be able to increase community awareness of this monumental problem. Increased awareness may increase "community readiness" to resolve the problem.

   Since this problem is so global, it may need to be approached through a higher legislative level. Tribal regulations and laws could be instituted regarding automobile safety and driving. eg., mandation of drivers' education classes.

2. Lack of recreational facilities and excess time of children were problems identified by community members according to key informants and the community heatlh survey. This identifies community "readiness" for these problems. These problems would also be very amenable to resolution if provided the resources. Since it would provide programs for the total population, it has far reaching implications.

   It may reduce excess time of children and adults, thus decreasing the incidence of alcoholism and delinquency. It may also reduce risk factors relating to disease processes such as obesity and cardiac arrest. It could also provide activities for the elder population.

3. Physical activity also reduces the amount of stress of an individual. This could also decrease the number of suicides and homicides present in the Pueblo, and other stress-related illnesses such as alcoholism. A recreational program in the Pueblo might also decrease mileage traveled in automobiles, thus decreasing motor vehicle accidents. Excess time of children is ranked equally with lack of recreational facilities, since they are interdependant problems. Recreational facilities, since they are interdependant problems. Recreational facilities may decrease excess time of children, and would provide more supervision to children. This would also assist children in making appropriate decisions about their lives, thus decreasing the amount of internal conflict with them.

4. It is estimated that 33% of the adult population and 25% of the youth population have alcohol related problems. This includes being a member of a family who has a problem drinker. Since alcoholism effects such a big percentage of the population directly and indirectly, it was ranked in the top ten.

   The community sees alcoholism as a great threat to the safety and welfare of the tribe. There were 152 alcohol related arrests in 1984. Since the Indian Health Service is responsible for providing this service for Isleta, the bureaucracy involved in establishing additional programs is great. This makes it less amenable to resolution, plus the fact that it is such a complex problem. More outreach and preventive programs need to be instituted, which is not funded through the Indian Health Service. Also, better contract services to provide rehabilitation or detox units needs to be looked at. More monies are needed to be delegated to the Pueblo for these services.

5. Obesity was identifed as a problem by the heatlh fair screenings, even though incidence rates show that people are not seeking help for this problem.

   Since it remains a cultural value that "plumpness" is healthy, readiness of change may vary within the population groups. The younger individuals who are giving up some of the past cultural values would be the easiest target group.

   Programs that inform individuals of the health risks related to obesity, plus innovative weight reduction programs would be valuable. Developed, with cultural values in mind, would allow the residents to retain past values, while in the process of attaining maximum wellness.

   Since obesity is a risk factor to many of the diseases prominent in the Native population, it needs to be considered in the planning of the health care for this population.

6. Even though mortality rates for Isletans are lower for cancer, malignant and benign, than for New Mexico or the United States, it remains a health problem for Isletans. This problem was identified by statistics and key informants.

   Many residents are affected by this problem indirectly, and it provides for 20.69% of the mortalities. However, this does not include other cancers that were not tumor-related.

   The Indian population is at risk for contracting different types of cancer, as discussed in analysis of neoplasms. The implications for these types may be preventable or better controlled if earlier screenings were instituted, if obesity was controlled, more nutritional programs developed, and more women's health services were offered.

6. Cont'd

   The low incidence rates for neoplasms of Native Americans is probably not an accurate reflection of the total problem, since many die at earlier ages before they are at risk in developing this disease. Therefore, incidence rates were not used as an indicator for the prioritization of this problem.

7. Since the environment plays a major role in the epidemiology of diseases, accidents, and injuries; environmental health was prioritized in the top ten. It was also an identified need according to the health survey and key informants.

   The Indian Health Service seems to be doing an adequate job on coordination and consultation with the Pueblo, regarding environmental health, however tribal interventions could be improved.

   The "readiness" of the tribe and residents is questionable, however, the cultural value of "living in harmony with nature" still persists and needs to be utilized creatively in cleaning up the environment.

   The incidence rates of injuries and communicable diseases, which were substantial, could be reduced if more consideration was given to this area.

8. Isolation of the elderly has been a problem. Some elders do not want to, or are unable to leave their homes, where more in-depth outreach programs would be helpful. eg. - full time nurse or health professional to provide assessments and coordination of activities, volunteer calling program, to contact elders daily to make sure that things are O.K. with them, and more innovative programs to draw them to the elders center. A new van with wheelchair capabilities would also be helpful, since many of the elders have physical limitations.

   Including them in health related activities such as the annual health fair is essential.

   This is a problem that the community has identified strongly within the health survey and one in which community "readiness" is present.

9. Since years of lives lost for suicide was 51.5 years and for homicide - 38 years; they are both similar problems for the Pueblo.

   Both possibly have etiologies relating to stress and environment. By providing stress workshops, culturally relevant to the targeted population, this might help reduce both rates. Also working on some of the above identified problems might reduce the occurrence such as alcoholism and lack of recreational facilities.

   Suicides, since they occur at a younger age might be prevented by instituting more self esteem and self awareness classes at school.

   Homicides could be directed at all age groups with more mental health programs offered.

10. The incidence of female genitalia and lack of a women's health program is also an identifiable problem, through statistics and key informants. If there were a women's health program targeted to this population, the incidence of female genitalia problems, UTI's, and cancers of the breast and cervix might be reduced.

    More outreach program are also needed to get these women in earlier for their care.

    The prenatal clinic is a good example of how effective a targeted clinic can be since it has substantially decreased neonatal deaths and mortality rates related to pregnancies and has improved the health of both mother and child.

    If a women's health program could be implemented, women could also gain emotional support from this, thus increasing self esteem and willingness to accept self care responsibilities.

    There were several problems identified at Isleta that were not included in the prioritization list. Otitis media seems to be managed well with early intervention taking place, even with its high incidence rate. Diabetes has also been an identified problem for years, however, the diabetes team provides excellent care for this population. Congenital anomalies accounts for many years of life lost, but as stated earlier in this report; prenatal care at Isleta is available and has been providing excellent care for this population. Communicable disease, hopefully would be reduced if the environment and other above priorities were worked on. Working with the top ten priorities to provide more extensive services in these areas, hopefully would reduce many of the other non-prioritized identified problems.

PRIORITIZATION OF PROBLEMS

1. Motor vehicle accidents can be considered the priority health probelm at Isleta because it is the only mortality rate which shows Isleta significantly higher than the United States rate and bacause it is the leading cause of years of life lost due to premature deaths. Clearly an effort should be made to educate the Isleta residents in relation to the severity of this problem and to enroll all drivers in defensive driving courses. The defensive driving course should also include education about responsibilities of friends and friends and family members not allowing individuals to drive while under the influence of alcohol.

2. Although deaths directly related to alcoholism appear to be low, alcoholism may be implicated in other causes of death such as motor vehicle accidents and homicides. It is also implicated in other problems such as domestic violence. While maintenance programs are currently provided for Isleta residents, the area of prevention is being neglected. Through prevention programs such as the one formerly provided at the BIA school, much of the problem of alcoholism may be avoided.

   It is the responsibility of the Indian Health Service to provide the means of treating alcoholic Indians in in-patient facilities as needed. Currently there are no facilities to provide effective detoxification and in-house rehabilitation for Isleta residents. As long as this situation continues, there is little hope of reducing the current status of the problem. Maintenance programs such as the one provided at Isleta are a necessary part of the solution but are only one part of a complex network of approaches needed to provide a comprehensive plan.

3. Obesity is selected as the third priority health need for Isleta Pueblo. Prevention of obestiy could considerably reduce problems for which it is a major risk factor such as diabetes, hypertension, and heart disease and cerevrovascular disease. Reduction of the problem includes changing, includes changing dietary and exercise habits of the people. This is not a small undertaking and necessitates a community approach to educating the people on the risk factors of obesity and the changes needed to reduce the problem including creative ways to continue important cultural traditions without the continued risks involved in the current style of eating. As stated in the goals of the Diabetes Project, the schools are a good place to start with early detection and treatment of the problem.

3. Cont'd

   A readiness of the community to change exercise patterns has been evidenced by participation in the Fun Run at the Health Fair and in the aerobic dance classes. Thus it is a good time for the community to make every effort to support the people in making important changes in their life style that will lead to better health. Antoher important effect of regular exercise is a reduction in stress levels. Increased stress is a factor in many of the health probelms cited in this report.

4. Excess unsupervised time of the children and lack of recreational facilities are ranked together in part because of their interrelatedness and in part because of their equal impact on other identified probelms of the Isleta community.

   The fact that the children have excess unsupervised time may be in part related to the lack of recreational facilities in which to house programs which will make positive use of that time. Lack of recreational facilities also has relevance for the adults at Isleta. If there were facilities available for participating in enjoyable physical activities, an increased exercise level might be reached by many Isletans. It has already been noted that there is a relationship between exercise and weight control, diabetes, and stress levels.

   Implications of unsupervised time of the children are fairly clear for beginning alcohol abuse and vandalism. Programs for children could incorporate some positive psychological approaches such as dealing with acculturative stress and other problems of growing up in addition to pure entertainment.

   Community support for solving these problems appears to be high, based on the results of the community health survey.

5. Isolation of the elderly is accorded a rank in the top ten areas for concentration of effort primarily because of the importance placed on it by respondents to the community health survey. Means of approaching this problem have already been discussed. The first step is consulting with the elderly to determine their desires or what they feel their needs are.

6. The analysis of data related to cancer showed that Isletans do not have a much lower rate for cancer than comparison populations as is a commonly held misconception. Examination of rates for Indians vs. non-Indians showed that for some types of cancer, New Mexico Indian rates are much higher than for New Mexico Anglos. This indicates the need for a different

6. Cont'd

focus on cancer prevention measures for Isletans. This would include both additional education of health care providers and then the community members of the cancer picture for Indians.

Even though the figures show low degree of premature deaths and low incidence rates, it is still felt to be a significant problem based on the analysis provided in this paper. Implications are for a change in the focus on this problem.

7. Environmental health is an area which currently has a capable person conducting surveillance and making recommendations which would substantially reduce environmental health risks if implemented. A ranking in the top ten areas is given to this problem because of the importance placed on it by respondents to the community health survey and because of the relative ease with which improvements in the problem can be made.

8. The women's health field represents basically an unmet need for the Isleta population. Women's health problems were ranked high for incidence rates and because there is no professional development of women's health programs in the Albuquerque Service Unit, it is felt that this is a need area requiring development of programs.

Rates for breast and cervical cancer are high among New Mexico Indian women. Preventive education in these areas could be included in a women's health program. Also because Indian women's rates for gallbladder cancer are high, prevention could focus in this area as well.

9. Suicide is included in the top ten priority problem list primarily because of its relationship to increased stress levels. It is felt that stress is implicated in many of the problems discussed and the suicide of a young person epitomizes the dangers caused by high stress levels. In developing a suicide prevention program, all areas of positive mental health would be addressed. A positive mental health of the population would go far in reducing the effects of stress which are evidenced in so many ways.

There are important problems from the analysis section of this report which have not been included in this list of ten top priority areas. Diabetes was not included because there

9. Cont'd

is an excellent program in place to deal with this problem. Congenital anomalies, while contributing a great deal to years of life lost, were actually few and all pregnant women at Isleta receive prenatal care. Therefore there is not much more that can be done to reduce this problem. Otitis media had a 7.0% incidence rate among the age group 0-4. However, there is little primary prevention for this problem and secondary level when people are seen at the clinic for these problems.

It is hoped that through concentration on the identified priority areas, much can be done to promote an overall increase in the health of the Isleta community.

RECOMMENDATIONS

Planned Fiscal Year 1985-1986

* Monthly Hypertension checks at the Elderly site.
* Monthly Hypertension and Blood Glucose checks on interested persons after the church services.
* Four Aerobic classes per week: two for beginners and two for advanced, weigh in weekly to determine weight change.
* One Fun Walk-Fun Run twice a year.
* Plan and give two education sessions per year regarding causes of hypertension and causes of diabetes.
* Work with the alcoholism program regarding client problems as the need arises.
* Plan and develop nutrition classes with Service Unit Nutritionist, focus on weight control.
* Plan and present a workshop for tribal members regarding cancer: importance of early detection and treatment
* Body changes classes will be presented to the fifth grade boys and girls and sixth grade boys and girls at the Isleta Elementary School twice during the school year.
* Coordinate efforts with Isleta Social Services and give presentations to Isleta Elementary School regarding child molestation/abuse. Continue to participate in and attend the monthly child protection team meeting.
* Maintain the current immunization status for three years and less. The current status averages 90 percent completed immunizations.
* Develop and present classes to teenagers regarding options to parenthood, through knowledge and birth control options. Begin planning for a Teen Clinic.

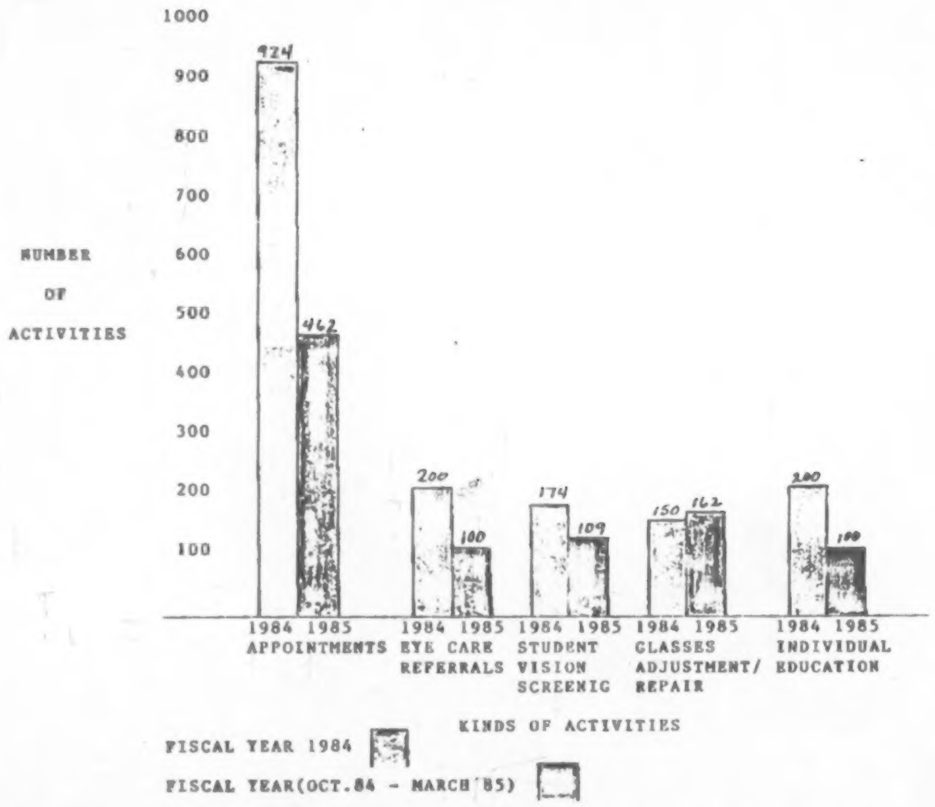
Recommendations, Cont'd

- Organize and present classes to teenage mother and fathers regarding prenatal, postpartum, and family planning issues. As well as encouraging the continuation of their education.
- Plan and present a Hunter Safety Class to those who will be hunting this fall.
- Coordinate and present to the Isleta Elementary School students to sessions regarding irrigation ditch safety.
- Distribute information regarding firework safety and give a presentation at the IsletaElementary School summer session regarding firework safety.

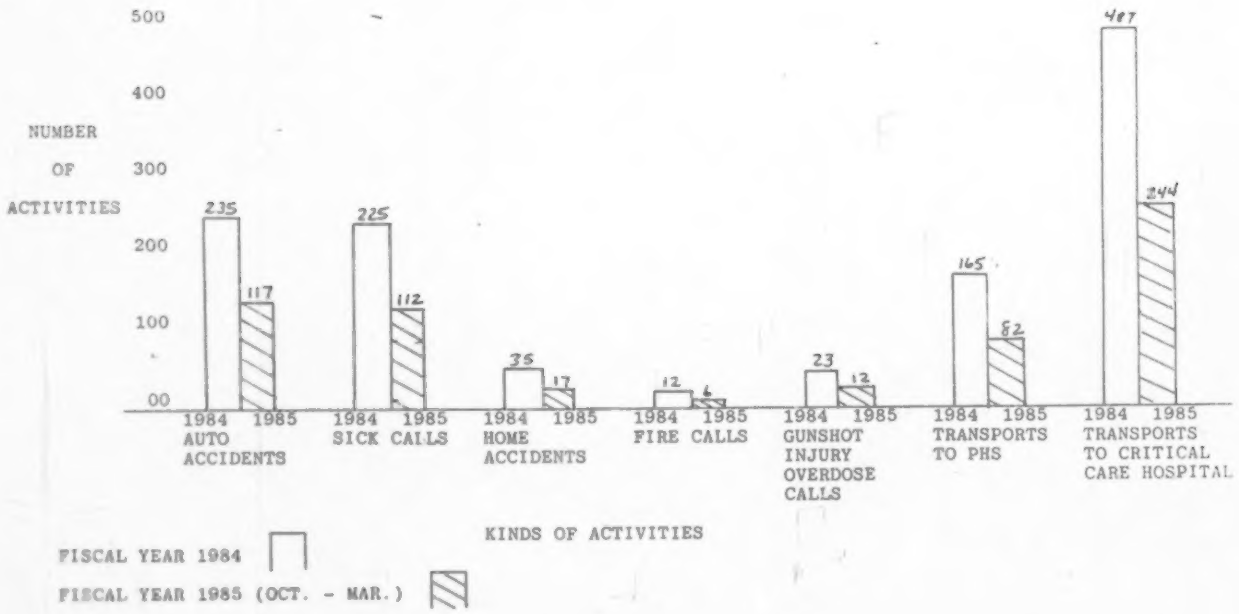
SUMMARY

The Isleta Community Health Representative Program provides thousands of services to the tribal members and is committed to serving the needs of the people. With the change in the emphasis of health care from treating sickness to promoting health, the Community Health Representative Program play a major role. Only with adequate funding and comprehensive support can this program be successful in serving the people and promoting health.

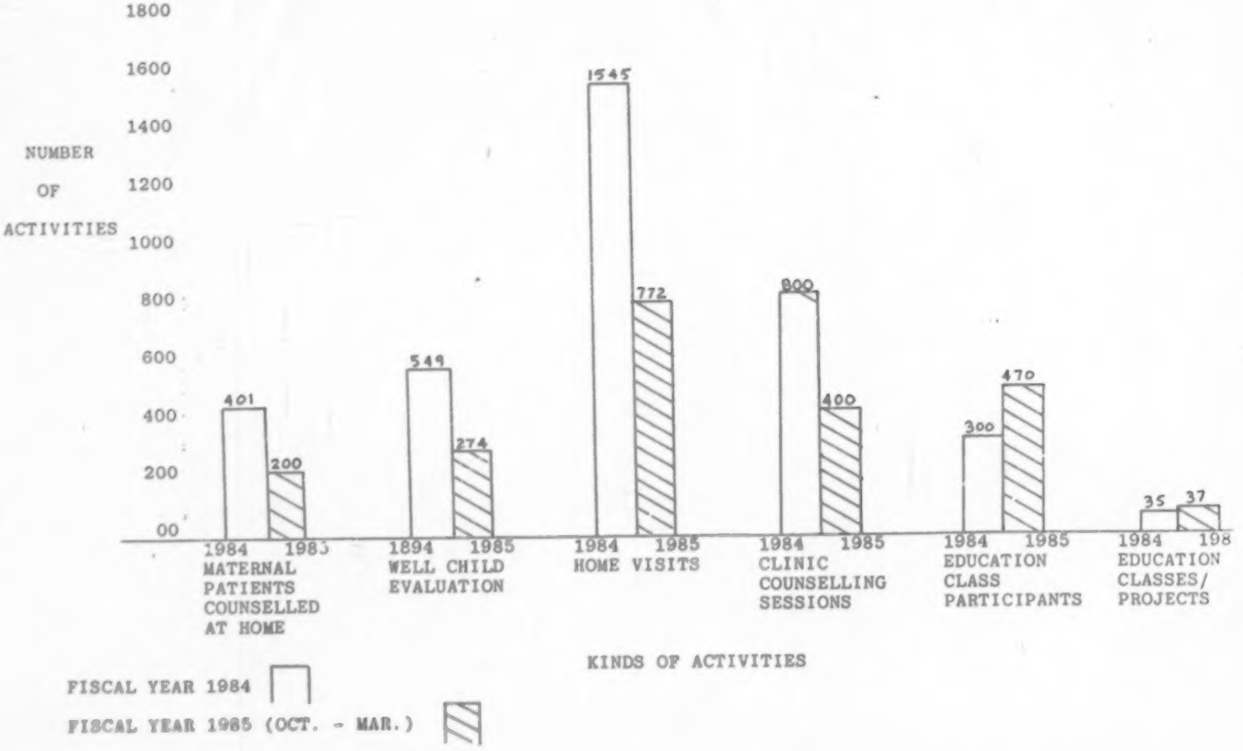
OPTOMETRY
HEALTH PROMOTION/DISEASE PREVENTION



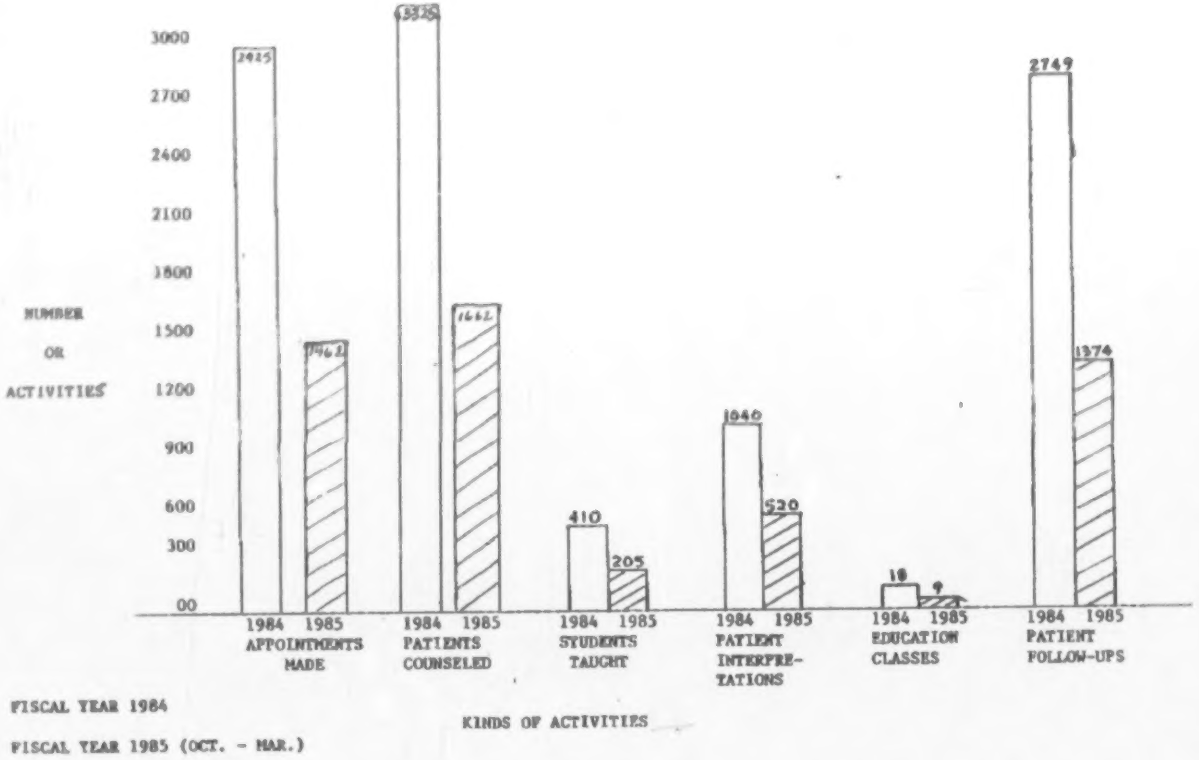
EMERGENCY MEDICAL TECHNICIAN -HEALTH PROMOTION/DISEASE PREVENTION



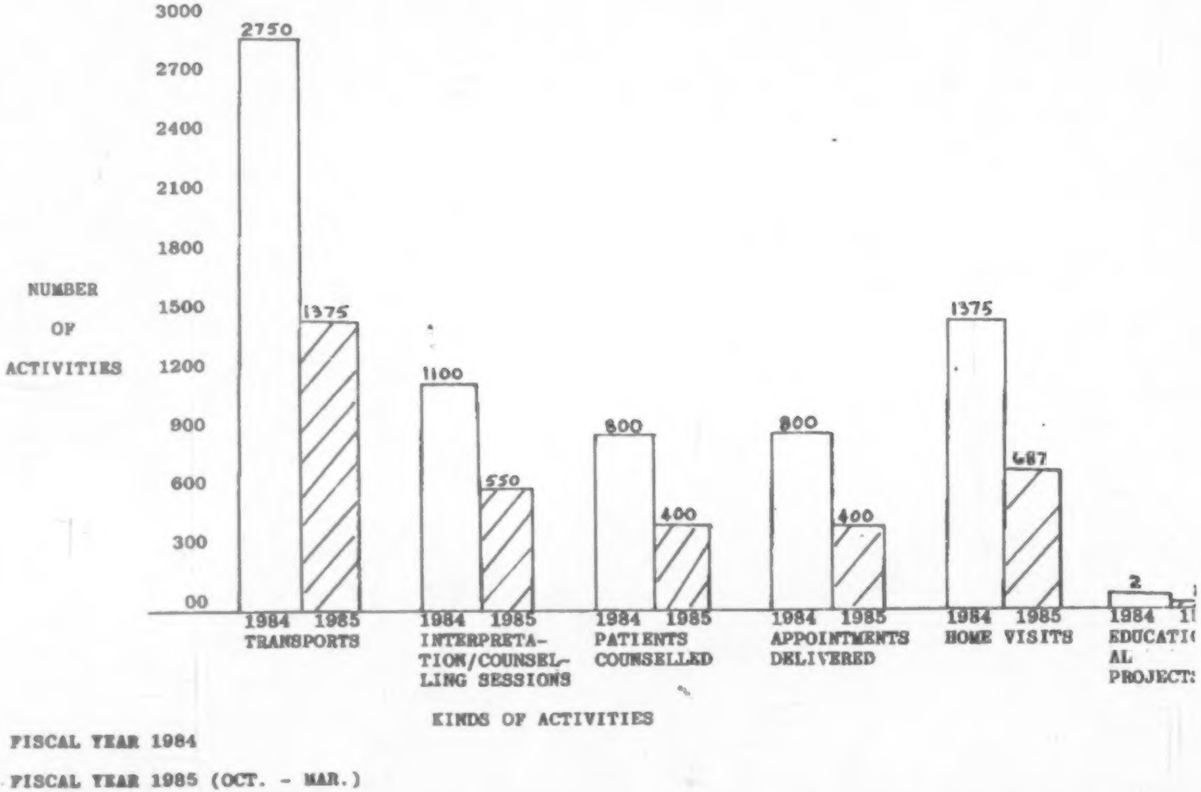
MATERNAL CHILD HEALTH/COMMUNITY HEALTH REPRESENTATIVE-HEALTH PROMOTION/DISEASE PREVENTION



DENTAL - HEALTH PROMOTION/DISEASE PREVENTION



GENERALIST - HEALTH PROMOTION/DISEASE PREVENTION



Senator BINGAMAN. Thank you very much. Who's the next one? Mr. Yepa here, yes, sir, Mr. Yepa. Glad you are here.

STATEMENT OF ANTHONY YEPA, HEALTH SERVICES ADMINISTRATOR, FIVE SANDOVAL PUEBLOS, BERNALILLO, NM

Mr. YEPA. Thank you, Senator. Mr. Chairman, Representative Richardson, Senator Bingaman, my name is Anthony Yepa, and I'm representing the Five Sandoval Tribes of Jemez, Zia, Santa Ana, Sandia and Cochitos that are located in central New Mexico.

Again, I'd like to thank you for the opportunity to be here to testify on behalf of S. 400 and encourage the enactment of this legislation.

I think I do not need to maybe reiterate the merits of the CHR Program at this time because I'm sure that the rest of the panel members will be doing that. However, I'd like to emphasize on the fact that national studies reveal that 90 percent of all medical expenses are spent on less than 3 percent of the population. And I believe that this is probably true with most of the Indian communities, so I think that this type of legislation is necessary so that we can keep the healthy people well.

And I think that this is the most important part and the significant part of S. 400. Again, the five Sandoval Tribes wish that the CHR program not be eliminated because of all the prevention activities that they are doing in their respective communities.

The Five Sandoval CHR Program, in fiscal year 1984, did roughly 5 percent of their activities in the areas of disease prevention and health promotion. And I think that this is quite true with most of the CHR programs, not only in New Mexico, but across the country.

One of the things that I would like to emphasize in the legislation is that you have identified the possibility of one to four demonstration projects to be initiated—I'm not sure whether it's going to be nationwide or where.

And we believe that maybe the demonstration projects will be channeled through existing 638 CHR programs for the following reasons: The CHR programs are the type of program that permits the tribes to take the initiative to identify the health needs and to oversee the management of such programming.

The model developed at the tribal level facilitates tribal planning, tribal acceptance and involvement in health promotion and disease prevention activities.

And, also, to work with one of the in-State universities I think is a very good idea because this would facilitate training for the CHR's as well as the BIA and the Indian Health Service.

And I think one of the positive reasons for channeling such programs through the 638 CHR programs is the fact that we are able to work subcontracts a lot faster and have demonstrated so with our prior CHR contracts.

And we hope that the evaluation mechanisms that have been established with the language that is in S. 400 will enable models to be developed from here on forward.

In summary, I would like to say that the Five Sandoval Indian Pueblo Tribes support S. 400, which by its enactment would improve the health and well-being of Indians. The health promotion and disease prevention strategies identified in this bill could have long-term benefits in reducing medical costs and improving health behaviors in our Indian people.

On behalf of the Five Sandoval Indian Pueblo Tribes, the communities of Cochiti, Jemez, Zia, Sandia, and Santa Ana, I wish to commend you for your efforts in supporting Indian health issues. And I hope that all of us will join in keeping well people well. Thank you.

Senator BINGAMAN. Thank you very much. We appreciate the testimony.

[Mr. Yepa's prepared statement follows:]

JEMEZ-COCHITI-SANTA ANA-SANDIA-ZIA

FIVE SANDOVAL INDIAN PUEBLOS, INC.

STATEMENT OF ANTHONY YEPA

FIVE SANDOVAL INDIAN PUEBLOS, INC.

ON S. 400 THE INDIAN HEALTH PROMOTION AND DISEASE PREVENTION ACT OF 1985

Mr. Chairman, my name is Anthony Yepa, I am the Health Services Administrator for the Five Sandoval Indian Pueblos, Inc. Five Sandoval Indian Pueblos, Inc. is a consortium of Indian Pueblos located along the Rio Grande River in Central New Mexico. Five Sandoval Indian Pueblos, Inc. is comprised of the Pueblos of Cochiti, Jemez, Sandia, Santa Ana and Zia; all located in Sandoval County, New Mexico where forty-five percent (45%) of the population is Native American.

Thank you for giving me the opportunity to testify before the Select Committee on Indian Affairs in support of the Indian Health Promotion and Disease Prevention Act of 1985.

Senate Bill 400 recognizes the need and benefits of the Community Health Representative Program. The Community Health Representative Program is recognized as the mainstay and forerunner of direct medical services, with emphasis on health promotion and disease prevention at the local Indian Pueblo communities. Within the Five Sandoval Indian communities, the Community Health Representatives provide approximately fifty percent (50%) of their time to direct health care services. The remaining fifty percent (50%) is spent on health promotion and disease prevention activities. In FY 84, six hundred thirty-six (636) such activities were made in the areas of hypertension,

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alcohol/drug abuse, heart disease, smoking, diabetes, wellness, and other areas. The total dollar amount of prevention services during this year has been calculated at $560,000. National studies reveal that ninety percent (90%) of all medical expenses are spent by less than three percent (3%) of the general population. Similar studies show that this trend is the same for the Indian community. By this example, the Five Sandoval Indian Pueblos, Inc. Community Health Representative health efforts were directed to maintain healthy lifestyles with the ninety-seven percent (97%) of the population who are well.

Five Sandoval Indian Pueblos, Inc. agrees with the Senate's Select Committee on Indian Affairs' recommendations of not eliminating the Community Health Representative Program and increasing funding at $26,652,000 for FY 86. The Indian Health Service's budget for prevention services does not reflect the stated Indian Health Services' goal of health promotion and disease prevention as a service priority for FY 86. It is well known that the Prevention Services category assures that health promotion and disease prevention efforts are carried out.

The Senate Select Committee also recommends a six percent (6%) increase for FY 85 appropriations level for alcoholism. The Five Sandoval Indian Pueblos, Inc. organization endorses the Senate Committees' and Senate Bill 400's recommendation of alcoholism prevention and services as a major goal of agencies working with Indian people. We are aware that preventive and education efforts are necessary in our communities to combat the number one health problem among Indians (Reference, Sandoval County Alcoholism Fact Sheet).

The Community Health Representative Programs, along with tribal health and social programs, and all Indian Health Service/Bureau of Indian Affairs providers, need a structured training program in health promotion/disease prevention. As health and social service providers, we need to enforce the traditional Native American health practices of holistic well-being. Senate Bill 400 emphasis training and curriculum development, as well as practical experience of health care prevention. We must realize that the health promotion/disease prevention is defined as changing our lifestyles, attitudes, and behaviors. This is a difficult task and will require the training support of Senate Bill 400 and the concerted effort of all agencies and tribes.

The development of a health promotion and disease prevention policy and services within Indian Health Services will enhance and address the health needs and services of Indian people. These types of policies and services are desirable, however, require tribal input. Tribal consultation should be included in the planning and development of prevention policies impacting Indian communities. Too often, Indian Health Services plans for Indian Health Services. Section 204 of Senate Bill 400, specifies the one to four demonstration projects be established to serve as models for the delivery of health promotion/disease prevention. Although this provision is not included in Senate Bill 277, Five Sandoval Indian Pueblos, Inc. agrees with the concept and recommends such programming be channelled through existing "638" Community Health Representative Programs for the following reasons:

1. The Community Health Representative, as a tribal program, permits the tribes to take the initiative to identify the health needs and to oversee the management of such programming.
2. The model developed at the tribal level facilitates tribal planning, acceptance, and involvement in health promotion/disease prevention efforts.
3. Sub-section (c)(1) describes the use of State University, Institution or public/private entity for training in the techniques of promoting health maintenance. Tribal contractors can enter into sub-contracts with these entities as demonstrated by tribal 638 contracts. Training should be available to all Indian Health Service/Bureau of Indian Affairs, tribal staff and tribal members.
4. The demonstration projects could be evaluated by an established Indian Health Services Area Group (comprised of Indian Health Service/Bureau of

Indian Affairs, tribal staff) upon completion of the projects. The initial evaluation being completed with the public/private entity and the tribe demonstrating the project.

The Five Sandoval Indian Pueblos, Inc. tribes support Senate Bill 400 which by its enactment could improve the health and well-being of Indians. The health promotion and disease prevention strategies identified in this Bill could have long term benefits in reducing medical costs and improving health behaviors of our Indian people. On behalf of the Five Sandoval Indian Pueblos, Inc. community Pueblos of Cochiti, Jemez, Sandia, Santa Ana and Zia; I wish to commend you for your efforts in supporting Indian health issues. Let us all join in on keeping "well people well."

Thank you for your consideration of our recommendations, and we will be pleased to respond to any questions you may have.

SANDOVAL COUNTY ALCOHOLISM
FACT SHEET

Based on NIAAA Epidemiological Study 1982 (based on 1975-77 death data and 1980 census), Sandoval County ranks fourth in state and eleventh nationally on a composite index of alcohol problems.

Sandoval County ranks number two in the state under the CHRONIC ALCOHOLISM category at a rate of 36.1 per 100,000 persons (NIAAA, 1982).

Sandoval County ranks number six in the state at a rate of 42.8 per 100,000 persons under the CIRRHOSIS OF THE LIVER category (NIAAA, 1982).

Sandoval County ranks eleventh in the state at a rate of 121.7 per 100,000 persons in the category of ALCOHOL INVOLVED TRAFFIC ACCIDENTS (NIAAA, 1982).

Sandoval County ranks second in the state at a rate of 54.1 per 100,000 persons in the ALCOHOL INVOLVED SUICIDE category (NIAAA, 1982).

Sandoval County ranks fourth in OVERALL ALCOHOL DEATHS in the state (NIAAA, 1982).

Sandoval County ranks number twenty-two in OVERALL ALCOHOL DEATHS nationally of the 3,103 counties in the United States. The county falls in the .1 percentile of counties nationally (NIAAA, 1982).

Sandoval County's alcoholism rate is 3.28 times the national rate (NIAAA, 1982).

Sandoval County ranks number two in New Mexico regarding DEALTHS ATTRIBUTED TO ALCOHOLISM (NIAAA, 1982).

Estimated number of alcoholic adults (DSM-III Diagnosis Alcohol Abuse and Alcohol Dependence) identifies 4,398 adult alcoholics and 721 treatable juveniles in Sandoval County (NIAAA, 1982).

There is no juvenile detention facility in Sandoval County. Juvenile offenders are sent to either Bernalillo or Valencia County centers (Carlos Pino, Sandoval County Sheriff, Santa Ana Pueblo, February 12, 1985.).

There is no women's detention facility in Sandoval County. The present facility at Sandoval County Jail does not accommodate the female offender (Carlos Pino, February

12, 1985).

The County Jail has felony offenders who remain at the County Jail because of over-crowding at the State Prisons. This creates over-crowding at the County Jail, thus leaving less space for misdemeanor offenders (Carlos Pino, February 12, 1985).

The Albuquerque Indian Hospital inpateint records show that eighty percent of all admissions are alcohol related diseases or accidents. Sandoval County population is approximately thirty percent of total population.

Seventy-one percent of adults arrested by the Bureau of Indian Affairs Police were alcohol related. Fifty-one percent of the adult male population arrested have been identified as problem drinkers.

Twenty percent of the female adult population are considered problem drinkers but this figure is probably higher because of the reluctance of apprehending female drinkers.

Overall, ninety-six percent of all Indian incarcerations were alcohol related offenses.

Sandoval County has been designated by the Secretary of Health and Human Services as a HEALTH MANPOWER SHORTAGE AREA/PRIMARY CARE, and MEDICALLY UNDER-SERVED AREAS as of July, 1983 (New Mexico Resources Registry, 1982-83).

Jemez, Cochiti and Santo Domingo Indian Reservations have been designated by the Secretary of Health and Human Services as REGISTERED NURSE (RN) SHORTAGE AREAS. There has been no new designation change since 1976 (New Mexico Health Resources Registry, 1982-83).

Senator **Bingaman**. Next is Frances Chavez, is that correct?

Mrs. **Chavez**. Right.

Senator **Bingaman**. Thank you for being here.

STATEMENT OF FRANCES CHAVEZ, CHAIRPERSON, HEALTH ADVISORY COMMITTEE, SANDIA PUEBLO, NM

Mrs. **Chavez**. Senator Bingaman, Senator DeConcini, Representative Richardson, I'm glad to be here today on behalf of our volunteer health advisory committee. Because we are such a small pueblo, we only have two CHR's in our community. And we are fortunate that we—we did have only one. Within the past year, we were awarded another CHR.

And Sandia is part of the Five Sandoval Indian Pueblos, and we are one of the pueblos that is closest to a major hospital, but because we are the smallest community, we only have a doctor that comes in 10 hours a month.

And we feel—we strongly support that the CHR programs continue because CHR's in our community are the first responders to any of the health needs in the community, to our elderly and to our youth.

And out biggest problem, again, is alcohol and drugs. And they have been very effective in dealing with disseminating information on prevention of drugs and prevention of diseases.

So we concur with the Five Sandovals and with all the All Indian Pueblo Council, and we support the bill, S. 400, on behalf of the CHR programs.

Senator **Bingaman**. Thank you very much. Did you have more?

Mrs. **Chavez**. No, I don't. Thank you.

Senator **Bingaman**. OK, fine.

[Mrs. Chavez' prepared statement, on behalf of Sandia Pueblo, follows:]

STATEMENT OF MRS. FRANCES CHAVEZ, CHAIRPERSON, HEALTH ADVISORY COMMITTEE, PUEBLO OF SANDIA

Mr. Chairman, I appreciate the opportunity to be here today. My name is Frances Chavez. I am the chairperson of the Sandia Health Advisory Committee, which is empowered to act as advisory board to the Sandia Tribal Council and its community on matters pertaining to health and social development.

Sandia Pueblo is one of five Indian pueblos that belong to the organization of Five Sandoval Indian Pueblos (FSIP). Of the five, Sandia is located closest to the major hospital which is 24 miles away in Albuquerque. The Pueblo has general medical clinic service approximately two-and-one-half hours per week, for a total of ten hours a month, of community medical care through Indian Health Service. The Community Health Representative (CHR) program is very important to us because it consistently provides Pueblo people in Sandoval County with necessary medical services through Indian Health Service funding. Because the Department of Health and Human Services has designated the area as medically underserved, these health services would not be available but for the CHR program and funding.

Sandia Pueblo feels fortunate to have two CHR's in our community, since these representatives are the first responders to local health needs. The CHR program must be continued because it provides health maintenance and acts as a starting point for any reservation health care and prevention programs. We concur with remarks by the Five Sandoval Indian Pueblos organization that is testifying today. And we are in support of S. 400 as introduced by Senator Bingaman.

S. 400 is desirable legislation because the three provisions which it proposes to add to the Indian Health Care Improvement Act will be beneficial to increasing long-term health standards for Indian peoples. The three provisions are: 1) development of a health promotion and disease prevention Indian health policy; 2) inclusion of health promotion and disease prevention services within the Indian Health Service, and; 3) continuation and improvement of the Community Health Representative Program as the vehicle to carry out such health promotion activities.

We especially concur with the recommendation at Section 204 for one to four nationwide demonstration projects in order to develop the most effective and cost efficient means of providing health promotion and disease prevention services. We too believe that such projects are necessary to improving Indian health care and to reducing health care costs in the long run. We recommend that one of the projects be authorized for implementation by the Five Sandoval Indian Pueblos organization in New Mexico. This is desirable because the usefulness of such concepts can best be tested by implementing them where existing Indian health care providers have ongoing CHR programs. FSIP's testimony details reasons why this approach will be the most effective.

Thank you for this opportunity to provide the committee with our strong endorsement for passage of this legislation as introduced by Senator Bingaman.

Senator **Bingaman**. I gather the next witness is Tom Lujan, is that ——

Mr. **Lujan**. That's correct, Senator.

Senator **Bingaman**. OK. Tom, go right ahead. We're glad you're here.

Mr. **Lujan**. Honorable Senator DeConcini—I have a hard time with that name.

Senator **DeConcini**. That's good.

STATEMENT OF THOMAS J. LUJAN, SUBSTANCE ABUSE IN-PATIENT TREATMENT AND PREVENTION PROJECTS, EIGHT NORTHERN INDIAN PUEBLO COUNCIL, SAN JUAN PUEBLO, NM

Mr. **Lujan**. Representative Richardson, Senator Bingaman, members of the committee, honored guests, ladies and gentlemen, my name is Thomas J. Lujan, and I'm a member of the Taos Pueblo. Also, the director of social services for the Eight Northern Indian Pueblo Council and for whom I will be presenting this testimony today.

I feel privileged to have the opportunity to present this testimony, which is supported and commonly shared by Governors as well as Indian tribes nationwide, on what is being proposed under S. 400 by our Honorable Senator Jeff Bingaman of New Mexico.

The Eight Northern Indian Pueblo Council is an intertribal association comprised of the northern pueblos of Taos, Picuris, San Juan, Santa Clara, San Ildefonso, Pojoaque, Tesuque, Nambe, which has a population of over—well, over 7,500 people.

The services provided by the Eight Northern Indian Pueblo Council include various Federal, State and some private funding programs in the major areas of social, health, education, and economic development.

The topics specifically assigned for me to testify on are in the areas of pueblo substance abuse, prevention treatment, and control. And at this point, I would like to bring an awareness that I choose to be very candid.

I will take a quote from one of our wise Indian leaders who once said:

> My valued people, it has been our misfortune to welcome our friend, the white man. We have been deceived. He brought with him shiny things that pleased our minds.
>
> He brought with him weapons more effective than our own. Above all, he brought with him the spirit water that makes us forget old age, weakness, and sorrow. I wish to say to you, my dear people, if your wish is to possess and accept these things for yourself, you must begin anew and put away the wisdom of our fathers.

Down through the centuries, our fathers and their fathers have lived on this planet. We can only accept that the addiction to alcoholism that you gave to our Indian people at a bargain has now become not only our No. 1 health problem, but also pueblo enemy No. 1 and a cause of many other problems related to alcohol.

The outstanding—and I wish to bring awareness, also, that there are some outstanding things that we are developing at the Eight Northern Pueblo, in particular, a prevention program as well as a half-way house. And, also, there are some things that we are working on that has the input of most of the tribal members, and this is on how we control alcoholism and drug abuse coming on our reservations.

The outstanding prevention model of the Eight Northern Indian Pueblo Council is the San Juan Pueblo Youth Dance Group. There are other dance groups within our other seven pueblos just as good, just as excellent.

It is important that I mention that tribal courts on this pueblo referred to the Indian youths that were once labeled as incorrigibles. That was several years back. Nobody could handle them. The way that this dance group had started, nobody could handle those young people.

The young adults had a need to identify with their Indian culture. For various reasons, they had just gone away from it. Through these trying times, the youth requested of their prevention program to initiate a different approach, which involved the teaching of their native culture, languages, and dances.

The outcome had a tremendous impact not only on the youth themselves, but also their parents, which in effect culminated in having a closer friendship in which each one valued the other, learning a new skill which is appreciated and valued by one's peers, being accepted by peers even when one makes mistakes, learning about the importance of participation in one's cultural heritage.

The other end result, not less important, is the positive development of our young adults spiritually, psychologically, and physiologically, which results at us retaining our heritage and culture which are invaluable to all of us on this planet.

Of the Eight Northern Indian Pueblo Council the methodology incorporated towards preventing, treating and controlling alcohol abuse and alcoholism are a unique halfway house treatment center for recovering alcoholics that employs vocational training and small-scale farm and livestock projects, the goal being self-sufficient due to use of the actual hands-on approach concept, which will impact on agricultural and academic development at the pueblos, which is already taking its effect.

The halfway house prepares the recovering alcoholics to reenter a family and community environment, which—with meaningful and purchasable skills.

We at the Eight Northern Indian Pueblo Council will nurture, and we're in the stages of nurturing, the concepts of control by the development implementation of the following criteria. And this is our thing, the permanent tribal members of our eight pueblos.

We intend to identify cultural factors associated to alcohol abuse in native American communities, in particular, to the eight pueblos.

Based upon the identification—the following is what we intend to do. Based upon the identification of the causal factors, we plan to develop native American-geared alcohol and alcoholism education program, education programs, whatever they might be.

Educational material will be adapted so all Native Americans can relate. Training needs will be based on research finding in the development of alcohol prevention, modalities for pueblo Indians, tribal urban and rural populations. By "rural populations," I mean, we have many Spanish people right within the immediate perimeters of the reservation. If there is going to be an attitudinal change, I think they also should be affected by it.

Based upon research conclusions, all of this supports the goal of developing totally therapeutic communities from primary prevention to secondary prevention.

We are doing this on a very minute scale because our facilities and human resources are limited. And I need to—I don't think I'm taking that much time. I'm trying to go as fast as I can. But there is a statement that Senator Anderson, in his introduction H.R. 277?

Mrs. CHAVEZ. Senate bill.

Mr. LUJAN. S. 277 stated, "I need to continue targeting Federal resources to address the health problems of Indians." I think it's well to know the percentages—66.4 percent of most Americans will live to age 65 or older, but an Indian child born today has only 35 percent of reaching age 65. The fact is that 40 percent of all Indian people are dying before they reach 45. These are realities I cannot afford to ignore, that we cannot afford to ignore.

Other concerns facing NIPC today involve around health promotion, disease prevention services to Indians. This includes other programs such as coordinating community Indian home care, women, infant and children projects, food commodities, community health representatives, the elderly and the Head Start.

In conclusion, two recommendations supported by our Governors include a request of national leaders to conduct field hearings addressing Indian health and social issues.

Also, another request to implement a nationwide campaign to reduce child abuse, substance abuse through social programs.

We feel S. 400 will give us the tools to continue to research development of alcoholism prevention models and substance abuse control through education to our tribal members of the devastating effects of alcohol to our physical and mental well-being.

Before I close, the Eight Northern Indian Pueblos Council Governors will submit their lengthy statement at a later date, which specifically was pointed out to me in 3 weeks.

Thank you for allowing me this privilege this day.

Senator BINGAMAN. Thank you very much, Tom. That was excellent testimony from all of you, and we appreciate that.

[Mr. Lujan's prepared statement, on behalf of the Eight Northern Indian Pueblos Council, the referred to statement of the Eight Northern Indian Pueblos Council Governors, and additional pertinent material, follow. Testimony resumes on p. 122.]

EIGHT NORTHERN INDIAN PUEBLOS COUNCIL

TESTIMONY ON SB 400

GALLUP, NEW MEXICO

THOMAS J. LUJAN, DIRECTOR OF SOCIAL SERVICES

SATURDAY, JUNE 1, 1985

EIGHT NORTHERN INDIAN PUEBLOS COUNCIL

TESTIMONY ON SB400 - SENATOR BINGAMAN

SATURDAY, JUNE 1, 1985

GALLUP, NEW MEXICO

HONORABLE SENATOR DeCONCINI, SENATOR BINGAMAN, MEMBERS OF THE COMMITTEE, HONORED GUESTS, LADIES AND GENTLEMAN:

My name is Thomas J. Lujan, a member of Taos Pueblo also the Director of Social Services for the Eight Northern Indian Pueblos Council and for whom I will be presenting this testimony today.

I feel privileged to have the opportunity, to present this testimony which is supported and commonly shared by our Governors as well as Indian Tribes Nationwide on what is being proposed under SB 400 by our Honorable Senator Jeff Bingaman of New Mexico.

The Eight Northern Indian Pueblos Council is an Inter-tribal Association comprised of the Northern Pueblos of Taos, Picuris, San Juan, Santa Clara, San Ildefonso, Nambe, Pojoaque and Tesuque which serves a population of over 7500 people. The services provided by the Eight Northern Indian Pueblos Council include various Federal, State and some Private funded progams in the majors areas of SOCIAL, HEALTH, EDUCATION AND ECONOMIC DEVELOPMENT. For information on the organization, please refer to Appendix #1.

The topic specifically assigned for me to testify on, are in the areas of Native American, more importantly Pueblo Substance Abuse, Prevention, Treatment and Control.

I will take a quote from one of our Wise Indian Leaders who once said " My VALUED people it has been our misfortune to welcome OUR FRIEND the White Man. We have been deceived. He brought with Him shining things that pleased our Minds, he brought with Him weapons more effective than our own. Above all, he brought with Him the SPIRIT WATER that makes us forget old age, weakness and sorrow. I wish to say to you, My Dear People, if your wish is to possess and accept these things for yourselves, YOU, must begin anew and put away the Wisdom of your Fathers." Down through the centuries that our Fathers and their Fathers have lived on this Planet, we can only accept that the addiction of ALCOHOLISM that YOU gave to our Indian People at a BARGAIN, has now become not only OUR Number ONE, NUMERO UNO Health problem, but also, PUEBLO Enemy Number One and the Cause of Many other Problems related to Alcohol.

The outstanding PREVENTION model at the Eight Northern Indian Pueblos Counci is the San Juan Pueblo Dance Group. It is important that I mention that the Tribal Courts on this Pueblo referred the

Indian youth that were once labeled as incorrigibles. The young adults had a need to identify with their Indian Culture. Through these trying times, the youth requested of their prevention program a different approach which involved the teaching of their Native culture and dances. The outcome had a tremendous impact not only on the youth themselves but also their parents which in effect culminated in:

1 -- having a closer friendship in which each one values the other

2 — learning a new skill that is appreciated and valued by one's peers

3 — being accepted by peers even when one makes mistakes

4 — learning about the participation in one's cultural heritage.
The other end results not less important is the positive development of our young adults spiritually, psychologically and physiologically which result at retaining our heritage and culture which are invaluable to all human beings on this planet.

At the Eight Northern Indian Pueblos Council, the methodology incoporated for preventing, treating and controlling alcohol abuse and alcoholism are a unique half-way house treatment center for recovering alcoholics that employs vocational training and a small scale farm and livestock project. The goal being self-sufficiency through a hands on-approach which would impact on agricultural and economic development at the Pueblos. The half-way house prepares the recovering alcoholic to re-enter a family and community environment with meaningfully and purchasable skills.

We at the Eight Northern Indian Pueblos Council will nuture the concepts of **CONTROL** by the development and implementation of the following criteria:

1 — Will identify causal factors associated to alcohol abuse in Native American communities.

2 — Based upon the identification of the causal factors we plan to develop Native American geared alcohol and alcoholism Edcational programs.

3 — Educational material will be adapted to relate to all Native American communities.

4 — Training needs will be based on research findings and the development of alcohol prevention modalities for Pueblo Indians, tribal, urban and rural populations.

5 — All of these was performed with the goal of creating concepts of total therapeutic communities.

6 — Based upon research conclusion, all of this supports the goal of developing totally therapuetic communities from primary prevention to secondary prevention and including tertiary prevention.

We are doing this in a very minute scale because our facilities and our human resources are limited.

Senator Andrews in his introduction of S. 277, stated a need to continue targeting federal resources to addres the health problems of Indians. **"While most Americans - 66.4 percent - will live to age 65 or older, the Indian child born today has only a 35 percent chance of reaching age 65. The fact is that 40 percent of all Indian people will die before they reach 45. These are realities that we cannot afford to ignore."**

Other concerns facing ENIPC today evolve around health promotion and disease prevention services to Indians. These include other programs such as: Coordinated Community In-Home Care; Women, Infants and Children; Food Commodities; Community Health Representatives; the Elderly; and the Headstart.

In conclusion, two recommendations supported by our Governors include:

A. Conduct field hearings addressing Indian health and social issues.

B. Have a nationwide campaign to reduce child abuse, substance abuse through social programs.

WE feel SB400 will give US the tool to continue the research, development of alcoholism prevention models and substance abuse control through education of the devastating effects of alcohol to our physical and mental well being.

Thank you for allowing me this privilege this day.

"APPENDIX I"

EIGHT NORTHERN INDIAN PUEBLOS COUNCIL

BACKGROUND

The Eight Northern Indian Pueblos Council (ENIPC) is a non-profit IRS designated 501 (c) (3) association of eight, distinct and unique Indian Pueblo Governments located in Northern New Mexico. The Eight Northern Pueblos are Taos, Picuris, San Juan, Santa Clara, San Ildefonso, Tesuque, Pojoaque and Nambe.

These eight Pueblos are located north of Santa Fe, the State Capitol of New Mexico. San Juan Pueblo serves as the Council Headquarters. The Pueblo of Tesuque, the Southern-most consortia member is approximately 10 miles north from Santa Fe while the Pueblo of Taos, the northern-most consortia member, is approximately 80 miles from Santa Fe. The other six Pueblos are located between these two. The topography in this area includes mountains, rolling uplands and alluvial valleys. Several rivers cross the area and provide water for irrigation. The economy of the area is based on tourism, agriculture, ranching, timber and mining with a significant portion of the Pueblo labor force working as skilled and professional workers with the State Government, federal programs and federally sponsored contacts, i.e., the Los Alamos Scientific Laboratories, the Zia Company, E.G. & G, etc.

The ENIPC had it's beginnings in the early 1960's when the individual Northern Pueblo Governors and their staffs met monthly to discuss common law & order issues. These meetings planted the seeds for comradeship, co-operation, co-ordination and strength in unity among the Northern Pueblo Governments. In 1965, ENIPC was officially recognized as a Community Action Agency eligible for Economic Opportunity Act Programs. As a formal organization in 1965 the ENIPC initially administered two programs, the Neighborhood Youth Corps Employment Program and Head Start. During fiscal year 1982-1983 the ENIPC is administering (40) different federal, state, local and private foundation grants and contracts with approximately 132 full-time staff, in addition to overseeing the management of an Adobe Bricks manufacturing/sales business, an Arts & Crafts outlet and a federally chartered Credit Union. The ENIPC Adobe Bricks operation has gained national exposure through the research collection and dissemination of Adobe Bricks as compared to other building materials for thermal efficiency and cost effectiveness.

The purpose of the ENIPC, as defined in the ENIPC Articles of Association, is to sponsor broad based community programs in the areas of Health and Social Services, Education and Economic Development.

Population

The eight Pueblos have a combined population of 7,137 according to the BIA Northern Pueblos Agency census figures dated June 1, 1982. The current BIA estimate is as follows:

Pueblo	Total	Married Heads of Household		Single Heads of Households
Nambe	478		94	114
Picuris	263	60	63	
Pojoaque	136	27	26	
San Ildefonso	571	106	114	
San Juan	1907	495	521	
Santa Clara	1443	332	309	
Taos	2017	375	513	
Tesuque	322	63	40	
TOTALS	7137	1552	1750	

3302 Family Units

Organization

The governing body of the ENIPC is the Board of Governors which consists of the eight respective Tribal Governors. The Governors of Santa Clara, San Ildefonso, Picuris, Pojoaque and Nambe are elected by their respective Pueblo members. San Juan, Taos and Tesuque Pueblos appoint their Governors through the traditional Pueblo process. Whether elected or appointed, the Board of Governors serve a one year term with all Eight Governors having an equal voice and vote. Previous Governors may continue on the ENIPC Board of Governors upon election or re-appointment as their respective Tribal Governor.

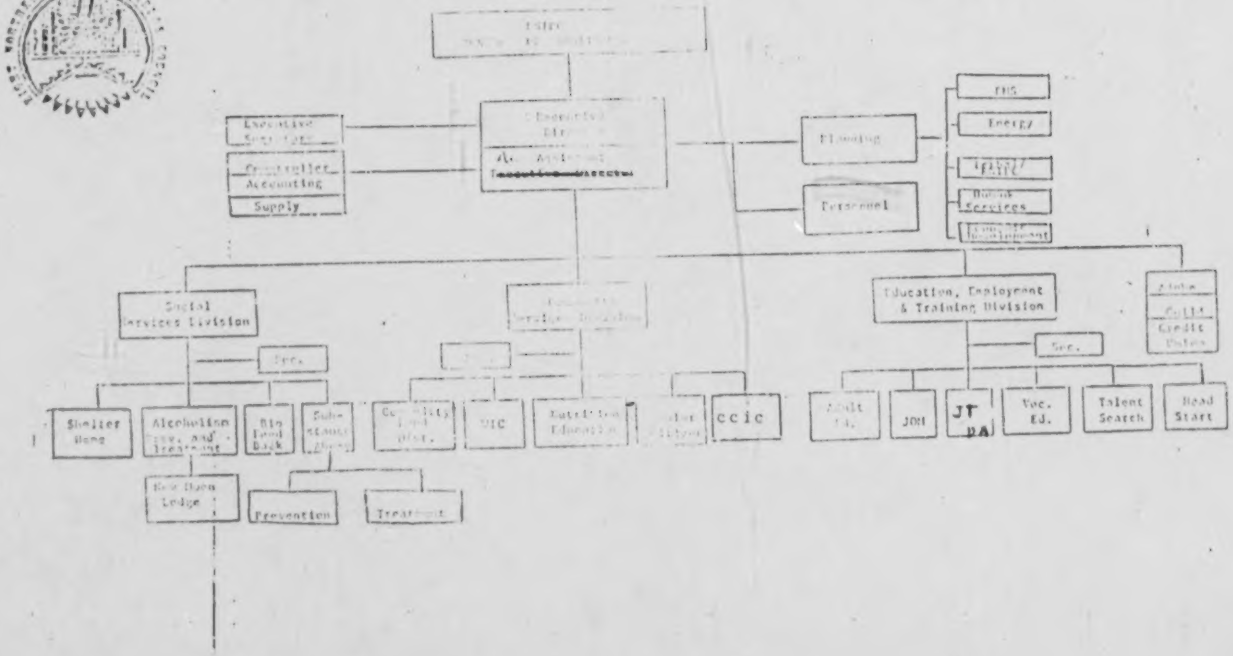
The ENIPC Board of Governors meets once a month on a date pre-determined during the January meeting, usually the second Tuesday of each month. Special meetings may be called by the Board Chairman or any two board members. Officers are elected at the January meeting and include one Board Chairman and one Vice-Chairman. The Chairman conducts all Board Meetings, represents the Council and acts as the Council spokesman. The Vice-Chairman acts on behalf of the Chairman during his absence. The Chairman is the titular leader with the Executive Director as it's chief Executive official.

The Executive Director of ENIPC is appointed by the Board of Governors and serves an indefinite term. The Executive Director is mandated to carry-out the mandates and policies of the Board utilizing generally accepted management principles and practices. The structure of the organization is found in the attached organizational chart. The organization is functionally graphed into five categories reflecting the mission of the ENIPC as defined in the ENIPC Articles of Association. These five areas include: (a) The Administrative unit comprised of the Executive Director and Assistant Executive Director's offices, the Accounting Department, the Planning Department and the Administrative clerical support staff. The administrative unit provides the overall management direction from the Executive Director's office while the administrative support is provided by the accounting, planning and clerical staff. The three divisional units provide the programmatic services with each division Director responsible for the overall divisional management. The Divisions are grouped into the following and provide the Social Services needs of the Northern Pueblos: (a) The Division of Social Services comprised of all therapeutic, out-reach services; (b) the Division of Community Services comprised of community based non-therapeutic services; (c) the Division of Education comprised of all education, training and employment services. The Division of Economic Development projects are comprised of all ENIPC revenue generating activities which provide a balanced strategy in meeting community needs through economic development.

It is important to realize that the ENIPC is an organization of governments and not a government in itself. Thus all Tribal self-governing functions remain the sovereign right of each of the Northern Pueblo Governments.

Planning for the Eight Northern Pueblos occurs at two levels: (1) locally at the individual Pueblo; and (2) regionally at the ENIPC. Although ENIPC is involved at both levels in varying degrees, most of its' planning focuses upon the overall regional impact of the Northern Pueblos. In line with social and economic self-sufficiency, most of the Northern Pueblo have the administrative and management capability to contract on an individual Pueblo basis. Thus, while the ENIPC is beginning to decentralize the provision of services at the ENIPC level to the Tribal level which is in line with the ENIPC complementary strategy of moving away from being consumers of services to becoming providers of services. In essence - a complementary strategy which is geared to stimulating the economic development of depressed areas and realizing self-sufficiency is essential to achieving permanent change. Although existing federal and state programs provide for social services, i.e., 40 different services via grants and contracts are provided through the Council, the ENIPC is developing revenue generating activities, projects, services, etc., in order to decrease the dependence on federal and state funds for Tribal services and needs. In addition to the development of revenue generating activities, the ENIPC places emphasis on the development of the internal capacity of Tribes to plan, develop and implement economic development projects in order to balance the growth and development of Tribal Governments.

Organizational Structure


Executive Director
Executive Secretary
Controller
Accounting
Supply
Planning
Personnel
EHS
Energy
Human Services
Education, Employment & Training Division
Sec.
Credit Union
Adult Ed.
JOM
JTPA
Voc. Ed.
Talent Search
Head Start
Social Services Division
Sec.
Shelter Home
Alcoholism Prev. and Treatment
Big Food Bank
Substance Abuse
New Dawn Lodge
Prevention
Treatment
Community Food Dist.
WIC
Nutrition Education
CCIC

EIGHT NORTHERN INDIAN PUEBLOS COUNCIL

P.O. Box 969
San Juan Pueblo, New Mexico 87566
(505) 852-4265

Testimony of the Eight Northern Indian Pueblos Council Governors re: 1) the inclusion of Child Abuse and Neglect in S. 400, Indian Health Promotion and Disease Prevention Act; and 2) inclusion of Child Abuse and Neglect as a related issue in S. 1298, the Indian Juvenile Alcohol and Drug Abuse Prevention Act.

The Eight Northern Pueblos Indian Council Governors have recognized child abuse and neglect as a serious and growing problem among their pueblos, as is true with the nation as a whole. Over half of the children from these communities identified as having been abused or neglected have family members who abuse alcohol and/or drugs. While the governors recognize that alcohol does not cause child abuse or neglect, it is clear that family alcohol abuse lowers parents' control over lashing out at their children when under stress and hurts parents' ability to care for their children. In addition, abused and neglected children are at greater risk for abusing alcohol and drugs, for other self-destructive and delinquent behaviors, such as suicide, and, when adults, abusing and neglecting their own children.

Statistics on abused and neglected children have been gathered by the Child Protection Team at the Santa Fe Service Unit Hospital, Indian Health Service, since December 1982. The Santa Fe Service Unit serves 12 tribes, 8 of which are the Eight Northern Indian Pueblos. Population size varies from 100 to 1600 per community, with a total population of over 7500. Since December 1982, the Child Protection Team has listed 107 children (including siblings) as abused or neglected, representing 60 families. Hospital service providers state that these numbers "only scratch the surface:" for every child identified at least 6-8 more children are known to be abused or neglected, but have not come to the hosital for services. Over half of the children identified come from the communities served by the Eight Northern Indian Pueblos Council.

What is also alarming is the number of adults receiving mental health or social services at the Indian Hospital who report being abused or neglected as children. Although statistics have not been collected on these adults, it is indicative of what is recognized by authorities and health providers as fact: child abuse and neglect is a problem that is passed on from one generation to the next.

At present, program services at all levels - agency and tribal - are not capable of addressing the needs of these children, their families, and adults who were abused as children. Yet, without serious intervention and prevention efforts right now, many more families will suffer in the future, and increase the need for services far beyond what are presently needed.

Efforts have been made to create community awareness as to the effects of child abuse and neglect on children, their families and communities, as well as related issues of alcoholism and domestic violence. Along with the Child Protection Team at the Indian Health Service hospital, a Community SCAN (Suspected Child Abuse and Neglect) Team was also organized three years ago. This team, made up of community health providers and Indian Health Service, Bureau of Indian Affairs, and State service providers, along with tribal and BIA police and tribal judges, has addressed the need for community awareness, foster care within the pueblos (see Eight Northern Indian Pueblos Council resolution on foster care, November 13, 1984), the development of tribal child protection teams (or multidisciplinary teams; see resolution by

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Santa Clara Pueblo, September 9, 1985), and the need for federal legislation which will enhance the ability of the federal government and the tribal courts to incarcerate, prosecute, and order treatment for offenders.

But this is only the beginning. In order to fully meet the needs of these and other Indian communities to break the cycle of child abuse and neglect, all out prevention efforts to educate parents, children, and other service providers, including medical staff, are vitally needed now. Further, intervention services must be strengthened and coordinated to assure appropriate treatment for children and families and timely prosecution for offenders. The coordination between service providers and legal personnel is especially crucial since, in the past 6 months, we have been seeing far more sexual abuse of Indian children come to light.

We do not have the resources or personnel to meet these needs. In fact, this year (FY 86) we have lost numerous key resources and personnel due to budget cuts. Further, we have never had the resources or facilities to properly prosecute, incarcerate and treat offenders.

We are asking for federal legislation to provide the vehicle for developing these resources at the local level: 1) on-going prevention and education efforts to end the cycle of child abuse and neglect; 2) an incarceration facility and resources for appropriate intervention, including prosecution and treatment, and 3) clarification of jurisdiction issues between tribal courts, the State, and the U.S. Attorney's Office to assure timely and appropriate legal response.

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By addressing child abuse and neglect in our Indian communities, we will be following the spirit of S. 400 by "improving the health and well-being of Indians" as well as "reducing medical expenses of Indian people" over time. These prevention and intervention efforts to end the cycle of child abuse and neglect will enhance and strengthen the health promotion issues listed in S. 400, particularly reduction in the misuse of alcohol and drugs, improvement of nutrition, and control of stress.

Thank-you for this opportunity to testify on child abuse and neglect on behalf of our Indian children.

EIGHT NORTHERN INDIAN PUEBLOS COUNCIL

P.O. Box 969
San Juan Pueblo, New Mexico 87566
(505) 852-4265

84 RESOLUTION # 24

WHEREAS, the Eight Northern Governors recognize the need for temporary placement of Indian children in Indian foster homes; and,

WHEREAS, the Community SCAN (Suspected Child Abuse and Neglect) Team of the Santa Fe Service Unit (SFSU), Indian Health Service, has identified 51 cases of child abuse and/or neglect since December, 1982; and,

WHEREAS, Child Abuse and Neglect has been shown to be inter-related to wife battering, alcohol and drug abuse, marital conflict and juvenile deliquency; and,

WHEREAS, the SCAN Team has experienced reluctance on the part of extended family members to place relatives' children to their homes; and,

WHEREAS, Indian children are being place inappropriately in institutionalized settings; and,

WHEREAS, the SCAN Team and other agencies have experienced legal and jurisdictional problems with the Tribes of New Mexico; and,

WHEREAS, the Indian Child Welfare Act mandates that Indian foster home placemants be developed and utilized.

NOW, THEREFORE BE IT RESOLVED that the Eight Northern Governors endorse and fully support the Community SCAN Team's efforts to develop a foster care plan and recruit and train Indian families for foster care placements.

CERTIFICATION

The foregoing resolution was duly considered and adopted at a meeting of the Eight Northern Governors on Nov. 13th. 1984, at which time a quorum was present and 8 voted for and 0 opposed.

ATTEST:

Chairman, ENIPC

SANTA CLARA
POST OFFICE BOX 580
(505) 753 7326

INDIAN PUEBLO
ESPANOLA, NEW MEXICO
87532

RESOLUTION No. 43

WHEREAS, The Social Services Program of Santa Clara has been experiencing an increase of reported child abuse cases and of child sexual abuse cases, and

WHEREAS, The primary task in responding to child abuse and child sexual abuse cases require child protection and legal prosecution, and treatment resources, and

WHEREAS, A Multi-Disciplinary Team (MDT) is essential to deal with child sexual assault cases where professionals review the cases and work cooperatively to improve case management, and pursue the legal enforcement requirements of prosecution and/or treatment, and

WHEREAS, Members of the MDT should participate in on-going training regarding the dynamics of child abuse and neglect and child sexual abuse issues; and be cognizant of current treatment approaches and current legal prosecution modalities, and

WHEREAS, The membership in the MDT should include persons who have been previously responsible for child protection and services, and that each team member shall have the authority to make decisions and commitments for their respective agencies. (MDT Organization Flow Chart attached).

NOW THEREFORE, BE IT RESOLVED, That the Santa Clara Tribal Council authorized the formation of the Multi-Disciplinary Team in order to systematically respond to child abuse and neglect and sexual abuse and that the MDT will include members of the child protection system (social services), criminal justice system (law enforcement), treatment and educational programs (BIA, PHS, and state resources), and

BE IT FURTHER RESOLVED, That the MDT shall deal with child sexual assault cases and child abuse and neglect cases where a viable approach towards improvement of case management, and where a access to reservoir of professional knowledge is in the community, and improved liaisons with consultants are utilized to provide child protection, legal prosecution and recommended treatment when and where warranted.

CERTIFICATION

We, the undersigned as Governor of Santa Clara Pueblo, do hereby certify that the foregoing resolution was adopted by the Santa Clara Pueblo Tribal Council at a duly called meeting on Sept. 9, 1985 at which time a quorum was present and the vote was 12 in favor and 0 opposed.

Lawrence P. Singer, Governor
Santa Clara Pueblo

ATTEST:

TESTIMONY

On Behalf of the COMMUNITY HEALTH REPRESENTATIVE PROGRAM

The Community Health Representative program has been a viable and necessary program since 1969 when it first began. This program is endanger of folding if the refunding does not occur for the coming years. Many viable services have been provided for the Indian population on the reservations which range from home visits to health education. Disease prevention and control are provided, with the continued followup services and monitoring of clients for the medical providers. Included with this testimony are statistical data that has been submitted by the Eight Northern Community Health Representatives on the services that they are providing.

If this program is cut as it is presently proposed, major changes in the health of our people would occur. Infant mortality would probably be seen again, there would be an increase of disease such as hypertension and diabetes out of control. The severity of injuries due to accidents would rise without this prevention program. As it is, the CHRs' provide emergency care for the injured and the ill and without them, the trauma would become more severe without the assistance of the CHRs' providing stabilization. Services provided by the Public Health Nurse could not possibly and adequately meet the health needs of the communities, since these persons are limited in the time that they spend in the communities. Daily contact in the communities would be impossible.

Transportation is also an essential part of the services that are provided since many of our people do not have transportation available to get them to a medical facility for needed medical care.

STATISTICAL DATA FOR THE COMMUNITY HEALTH REPRESENTATIVE PROGRAM FOR THE MONTHS OF OCTOBER THRU MARCH

Home visits	-	Over 7,000 home visits have been provided by 33 CHRs' for the follow-up and monitoring of illnesses or disease, for case findings of new illnesses or disease.
Interpretation	-	The CHR's provide interpretation to those clients not understanding the English language, medical directions and advise, and the directions on how to take medication that is prescribed.
Referrals from	-	Over 1,000 referrals from medical providers have been received that the CHRs' have taken care of for the monitoring or checking up on clients for the physicians.
Deliveries	-	Over 1200 deliveries have been made by the CHRs' which consist of delivering appointments, medication, medical supplies, information from IHS that keep clients up to date on medical care and information.
Counseling	-	The CHRs' have provided over 2,000 counseling encounters that range from group encounters, assisting families with coping with stress and problems experienced in the home, and individual counseling with clients suffering from stress, alcoholism and substance abuse, and other mental health disorders.
Health Education	-	The CHRs' are providing health education to over 2,000 clients. Education in the health areas such as safety, hypertension, diabetes, dental care and many more areas of health are being covered.
Follow-up Services	-	CHRs' are providing more than 2,000 follow-up services to clients checking up on illnesses or disease for close monitoring to prevent serious problems from occurring.
Referrals to	-	The CHRs' have referred more than 3,000 clients to a medical facility for medical care because of illnesses that need medical attention, accidents that have caused injury, and for the medical follow-up of diseases such as hypertension control.
Transportation	-	Many clients do not have transportation accessible to them and rely heavily on the CHR program for needed transportation to the medical facilities. Over 3,000 clients have been provided transportation services.

Personal Care - This area consists of providing services such as daily personal hygiene to those clients that are handicapped, or because of illness cannot take care of themselves without some assistance. Also provided are the checking of vital signs and blood pressures because of illnesses or disease. The CHR's are also providing foot care for the diabetics with the weekly checking of feet of the diabetic to prevent serious medical problems of the diabetic. Over 1,500 services have been provided in this area.

Screening - This is an area that the CHR will do daily to prevent health problems. Either by the checking of blood pressures or having community programs set up for the screening of other diseases or problems. This is also used for safety prevention.

Emergency Medical Svcs. - The CHRs' provide emergency medical care in the communities whenever and injury has occurred. They are either first respondors or EMTs' that work closely with the ambulance services in their areas. The majority of the CHRs' man these ambulance services as a part of their daily job description.

The CHRs' have very busy schedules as you can see. The average number of miles that a program puts on their vehicles each month range from 700 to 2,500 miles per month. Most CHR's work over the 40 hours per week that they are getting paid for with no type of compensation for the extra hours that they give to their communities.

Senator BINGAMAN. We have two additional witnesses, Bruce Leonard, with Zuni, the Zuni Public Health Service Hospital. Bruce, if you could go right ahead.

STATEMENT OF BRUCE LEONARD, HEALTH EDUCATOR, ZUNI PUBLIC HEALTH SERVICE, HOSPITAL OF THE INDIAN HEALTH SERVICE, ZUNI, NM

Mr. LEONARD. Senator Bingaman, Senator DeConcini, Representative Richardson, I would like to thank you for inviting me to testify at this important hearing. My name is Bruce Leonard. I'm working for the Indian Health Service as a health educator.

In the last 40 years, the prevalence of diabetes on Indian reservations has evolved from a rarity to a full-blown epidemic. The average white American has a 1-in-20 chance of developing diabetes. The odds among American Indians is 1 in 4.

In Zuni, it is estimated 1 out of 3 adults over the age of 35 have developed diabetes. Diabetes is a chronic metabolic disorder which affects the body's ability to metabolize food and energy.

Among Type II diabetics, there are not insulin receptors in the cells to absorb the glucose which is produced. The unused glucose accumulates in the blood to unhealthy levels, and it leads to very devastating complications.

In 1971, 55,000 outpatient visits to the Indian Health Clinics nationwide were attributed to this disease. In 1983 this number soared to a 154,000.

Diabetes is a leading reason for outpatient visits in Zuni last year. Among the complications that are caused by diabetes is kidney failure. In 1973 there was one case of kidney failure end-stage renal disease in Zuni. In 1984 there were 20 cases resulting in a cost of a service unit of $500,000 or $25,000 per patient.

Other complications attributable to Type II diabetes are retinopathy, stroke, coronary disease and nerve damage. These complications are occurring at an accelerating rate and will continue to be more costly to the IHS system.

The encouraging news is that Type II diabetes is a disease that can be prevented and controlled. Doctors have always known that obesity increases the risk of developing Type II diabetes. Now it is also known that weight loss somehow reduces blood sugar levels by increasing number of insulin receptors.

I would like to share with you a Zuni Diabetes Project that has been in operation since July 1983. It is an exercise education program which consists of five aerobic exercise classes a week. These classes are 45 minutes to 60 minutes in length and include exercises choreographed to popular music.

These exercise classes are supplemented by educational classes which provide information about physiology, nutrition, exercise and other diabetes-related topics.

Over 200 Zunis are participating in classes. Fifty of these individuals have experienced an average weight loss of 15 pounds. Twenty diabetics have been taken off insulin and now report normal blood sugars.

Since all Zunis are at risk of developing Type II diabetes, this class provides both primary and secondary prevention. Those Zunis who are participating and lose weight through exercise decrease their chance of ever developing diabetes. And those diabetics that exercise and lose weight, can often control their blood sugars without medication and prevent possible complications in the future.

This class has served as a catalyst of the development of other aerobic exercise classes and fitness activities in the Zuni community. When this class started in July 1983 there were two other weekly community aerobic classes available.

As of today, June 1, there are now 46 aerobic exercises classes available in Zuni a week. Many of those classes are being conducted at work sites that employ the largest numbers of Zunis. There are nine exercises classes a week offered at the Zuni Indian Hospital. Five classes a week are held for tribal employees. Daily classes are available at three different school sites.

In addition to these work site locations, aerobic classes are available to special population groups. There are three classes a week offered for senior citizens, three classes a week offered for substance abusers. Most of these classes are all conducted by volunteers.

Classes are offered every evening and on weekends for anyone in the community that is interested in participating. The Zuni fitness series is in its second year. It consists of five monthly road races, which last summer attracted 1,200 participants. We had our first road race. Two weeks ago we had 260 participants, and I've heard that Senator Bingaman is going to have a team coming to Zuni in August of five members to compete in a relay that will go completely around the reservation. I think you can talk to your aide.

Senator BINGAMAN. I'm glad to hear about that.

Mr. LEONARD. Each event includes a 2-mile noncompetitive fun run-walk along with a variety of other competitive distances. These activities not only serve to prevent and control diabetes, but effectively prevent heart disease, stroke, gall bladder disease and some forms of cancer and a wide range of other obesity-related diseases.

Increases in physical activity can also serve to promote health. As the individual's self image improves, and loss of weight increases energy, there can be a decrease in the dependence of alcohol or drugs, and we have seen that in Zuni as a result of these programs.

The Zuni Indian Hospital Exercise Program has demonstrated a 27-percent decrease in absenteeism for those participating in these programs. I think these programs demonstrate both a cooperative effort of both the Indian Health Service and the tribe. We work very actively with CHR's and other tribal health agencies in cooperation to put on these programs.

The Community Disease Prevention and Health Promotion Programs can work. And I hope through the passage of S. 400 we will have the moneys to support these kinds of community prevention programs. Thank you.

Senator BINGAMAN. I gather the next witness is Larry Curley. I see Larry right back here. Maybe somebody could make room here at the table so Larry could go ahead. Thank you very much for that testimony.

STATEMENT OF LARRY CURLEY, EXECUTIVE DIRECTOR, LAGUNA RAINBOW NURSING CENTER AND ELDERLY CARE CENTER, NEW LAGUNA, NM

Mr. CURLEY. Senator Bingaman, Senator DeConcini, Congressman Richardson, it's good to be here to talk with you one more time. I would like to right off at the very beginning, you have my testimony, what I'd like to do is just talk with you to share with you my thoughts and my concerns on the bill that you have introduced.

I believe it's a very good bill. I think it has some very good provisions. My name is Larry Curley. I am the executive director of the Laguna Rainbow Corp. The Laguna Rainbow Corp. is a nonprofit private organization that provides a total realm and continuum of health care services to the elderly people in the Pueblo Laguna.

Going back to the bill, I think it's a very good bill. I think it has some very good provisions. The question that I have is referring to elderly people. Now that we've kept them alive longer and are keeping Indian people alive longer, what do we have to offer them? I think the Indian elderly in this country, and I think there were some statistics that were cited earlier that indicate that Indian people at the age of 45 begin to exhibit characteristics typical of older non-Indians at age 65. In other words, Indian people get older faster and sooner than their non-Indian counterparts.

I run a nursing home on the Pueblo of Laguna, a 25 bed intermediate care facility. Of those 25, approximately 70 percent of that population have been diagnosed as having diabetes, and that it is the primary reason for their being placed in the ICF.

Second, 25 percent of my population are there because of alcohol-related problems or alcohol abuse in their younger years.

Forty percent of my elderly population within the nursing home are there diagnosed as having organic brain syndrome. And those, basically, are related to either head injuries or as an effect of prolonged alcohol abuse.

I find that in running the nursing home that the average age of my elderly people in that nursing home is 82, with the oldest being 107.

I'm sure if we could figure out how she did it, we wouldn't be having this hearing, Mr. Chairman. The youngest one is 61. In terms of wellness and health, I believe that the key is good nutrition.

And I think one of the questions that you asked earlier, Senator DeConcini, I believe the key to a lot of the problems related to diabetes is better nutritional education. I believe that the services that are provided to elderly people to keep them out of nursing homes are very, very much needed. I think the key to programs on Indian reservations to keep elderly people well and out of nursing homes is title 6 of the Older Americans Act.

However, I think in your State, Senator DeConcini, the State of Arizona, and the Indian tribes under the Title 6 Program have lost close to $100,000 in title 6 moneys.

In the State of New Mexico, Senator Bingaman and Representative Richardson, we have lost $100,000. How can we keep our elderly people well when the amount of moneys that are necessary to keep our elderly people well are being cut?

The $10,000 that the pueblo of Laguna lost represents to me, 5,000 meals, an average of about 100 meals a week that we lose in that community. And that's a lot.

And when you begin to take a look at the cost of services, we find in the pueblo of Laguna that providing counseling services, information and referral services, chore services, home health services, and other supportive services, that we served 300 elderly people last year at a cost of approximately $5.56 a day per person compared to the nursing home costs of about $72 a day.

Obviously, it seems to me that it is cost efficient, it is more humane to provide services outside of an institutional setting. I do also want to share with you, Senator Bingaman, in the State of New Mexico, we have roughly 8,000 elderly Indians in the State of New Mexico, and they say, "they say" meaning researchers, that 14 percent of that population at any given point in time are at risk of being institutionalized. And that 14 percent, Mr. Chairman, represents about 1,064 elderly people in New Mexico who are going to end up in nursing homes if those supportive services are not provided.

At a cost of $38 a day, Mr. Chairman, that's a cost of $40,432 a day. Annualized, that's $14 million.

I believe, Mr. Chairman, that the $100,000 in cuts that the State of New Mexico took in title VI should be reinstated and brought back into the State to at least begin to cut down on the potential costs that these kinds of cuts are going to have in our community. Thank you.

[Mr. Curley's prepared statement follows:]

LAGUNA RAINBOW CORPORATION
LAGUNA RAINBOW NURSING CENTER
& ELDERLY CARE CENTER

STATEMENT MADE BY:

LARRY CURLEY, EXECUTIVE DIRECTOR
LAGUNA RAINBOW CORPORATION
NEW LAGUNA, NM

ON:

JUNE 1, 1985
GALLUP, NM
U.S. SENATE SPECIAL COMMITTEE ON
INDIAN AFFAIRS FIELD HEARING

P.O. Box 235 • New Laguna, New Mexico 87038 • (505) 552-6034

GOOD MORNING, MR. CHAIRMAN AND OTHER MEMBERS OF THE SENATE SPECIAL COMMITTEE ON INDIAN AFFAIRS. IT IS A PLEASURE TO BE HERE WITH YOU TODAY TO SHARE WITH YOU, OUR THOUGHTS AND FEELINGS ON THE SUBJECT OF THIS HEARING.

MR. CHAIRMAN, MY NAME IS LARRY CURLEY. I AM THE EXECUTIVE DIRECTOR OF THE LAGUNA RAINBOW CORPORATION, A NON-PROFIT ORGANIZATION CHARTERED BY THE PUEBLO OF LAGUNA TRIBAL COUNCIL TO PROVIDE FOR THE TOTAL NEEDS OF THE ELDERLY RESIDING ON THE PUEBLO OF LAGUNA. THERE ARE 612 ELDERLY AGE 60 AND OVER ENROLLED ON THE CENSUS ROLLS OF THE PUEBLO. IN ADDITION, THERE ARE AN ADDITIONAL 400 BETWEEN THE AGES OF 50 AND 59. THIS, OBVIOUSLY REPRESENTS FUTURE ELDERLY THAT THE CORPORATION NEEDS TO BEGIN TO PLAN FORWARD TO. I AM ALSO QUICK TO ADD THAT THIS SITUATION IS NOT A MONOPOLY OF THE LAGUNA PUEBLO. ACCORDING TO THE NEW MEXICO STATE OFFICE ON AGING AND THE 1980 CENSUS BUREAU, 4.3% OF NEW MEXICO'S ELDERLY POPULATION IS INDIAN. IT WOULD BE SAFE TO ASSUME THAT THIS POPULATION NUMBERING 7,071 IN 1980 HAS INCREASED BEYOND 8,000 IN 1985. IN 1970, THE INDIAN ELDERLY OF THIS COUNTRY NUMBERED 64,000......IN 1980, THIS POPULATION GREW TO A TOTAL POPULATION OF 109,000! BY THE YEAR 1990, THIS POPULATION WILL EASILY EXCEED 200,000.

IT IS PLAIN TO SEE, MR. CHAIRMAN AND MEMBERS OF THIS COMMITTEE, THAT THE TIME TO BEGIN TO PLAN, DEVELOP, AND IMPLEMENT SERVICES IS NOW. I DO NOT BELIEVE WE CAN AFFORD TO WAIT.....BECAUSE IF WE DO, THE SCOPE AND MYRIAD OF PROBLEMS ASSOCIATED WITH THE PROVISION OF SERVICES TO THE ELDERLY WILL BE SO PERVASIVE AND ACUTE, THAT THE COST WILL BECOME A PIVOTAL BASIS FOR MAKING THESE COM-

MITMENTS.

THE LAGUNA RAINBOW CORPORATION, AS I STATED EARLIER, HAS BEEN CHARGED WITH THE RESPONSIBILITY BY THE PUEBLO OF LAGUNA TO PROVIDE A COMPREHENSIVE ARRAY OF SERVICES TO THE ELDERLY OF THE COMMUNITY. THESE PROGRAMS ARE DESIGNED TO ENHANCE THE INDIAN CONCEPT OF "THE FAMILY" AND "THE COMMUNITY". WE BELIEVE, THE PREFERRED SITE OF SERVICE DELIVERY IS THE HOME AND THEREFORE, THE SERVICES THAT ARE BEING PROVIDED BY THE LAGUNA RAINBOW CORPORATION ARE DESIGNED TO ALLOW THE ELDERLY TO REMAIN IN THEIR OWN HOMES AND COMMUNITIES. BY PROVIDING SERVICES IN THE HOMES OF THE ELDERLY, THEY CAN REMAIN A VITAL, FUNCTIONING AND CONTRIBUTING MEMBER OF THE COMMUNITY.

WE BELIEVE THAT THIS EFFORT TO BEGIN TO CONCENTRATE ON THE PROMOTION OF WELLNESS AND PREVENTION IS A CONCEPT THAT WE, AT THE CORPORATION, HAVE EXPENDED TREMENDOUS AMOUNTS OF ENERGY AND EFFORTS TO REALIZE. THE IDEA OF WELLNESS AND HEALTH WITHIN THE INDIAN COMMUNITY IS NOT A FOREIGN CONCEPT, INDEED, IT IS A CONCEPT THAT IS AT THE HEART AND ESSENCE OF BEING INDIAN. IT IS A CONCEPT THAT ENCOMPASSESS NOT ONLY PHYSICAL WELL-BEING, BUT INCLUDES THE SPIRITUAL ASPECTS, AS WELL. I BELIEVE, MR. CHAIRMAN, THAT TOO OFTEN FEDERAL AGENCIES AND DEPARTMENTS DIVIDE THE INDIVIDUAL INTO A VARIETY OF SEPARATE SPHERES AND ASSIGN THESE TO DIFFERING AGENCIES AND DEPARTMENTS. THUS, THE INDIAN COMMUNITY HAS TO GRAPPLE WITH PUTTING THESE PIECES BACK TOGETHER AT THE LOCAL LEVEL....SOMETIMES IN SPITE OF REGULATORY RESISTANCE. IN THE END OF THIS PROCESS, WE USUALLY END UP AQUIESCING TO THE POWER.

THE LAGUNA RAINBOW CORPORATION PROVIDES AN ARRAY OF SERVICES THAT RANGE FROM THE COMMUNITY-BASED NONINSTITUTIONAL SERVICES TO THE PROVISION OF NURSING HOME OR INSTITUTIONAL CARE. IN THE AREA OF COMMUNITY-BASED CARE, THE CORPORATION PROVIDES THE FOLLOWING SERVICES: INFORMATION AND REFERRAL, OMBUDSMAN, CONGREGATE MEALS, MEALS ON WHEELS, HOME-DELIVERED MEALS, CHORE SERVICES, PERSONAL CARE, COUNSELLING, TRANSPORTATION, RECREATION, PHYSICAL FITNESS, EDUCATION, TRAINING, ADVOCACY, SENIOR COMPANION PROGRAMS, OUTREACH, LEGAL , AND A LICENSED MEDICAID/MEDICARE HOME HEALTH AGENCY. TO COMPLEMENT THESE SERVICES DESIGNED TO KEEP ELDERLY IN THEIR OWN HOMES AND COMMUNITIES, THE CORPORATION ALSO PROVIDES NURSING HOME CARE IN THE FORM OF A 25-BED INTERMEDIATE CARE FACILITY. THIS FACILITY IS ALSO LICENSED AND CERTIFIED TO PARTICIPATE IN THE STATE'S MEDICAID PROGRAM. THE AVERAGE AGE OF THE ELDERLY RESIDING WITHIN THE NURSING HOME IS 82 YEARS OF AGE. THE OLDEST IS 107 YEARS OLD......IF ONLY WE KNEW HOW SHE DID IT, MR. CHAIRMAN, WE WOULDN'T BE HOLDING THIS HEARING! THE YOUNGEST PERSON IN THE FACILITY IS 63 YEARS OLD. IT IS NOT UNCOMMON FOR THE ELDERLY WHO ARE ADMITTED INTO THE FACILITY TO HAVE MULTIPLE DIAGNOSIS'. HOWEVER, APPROXIMATELY 75% HAVE BEEN DIAGNOSED AS HAVING DIABETES; APPROXIMATELY 40% HAVE BEEN DIAGNOSED AS HAVING ORGANIC BRAIN SYNDROME(OBS); AND APPROXIMATELY 25% HAVE HAD HISTORIES OF ALCOHOL ABUSE. AS A RESULT, THE FACILITY DEVOTES MUCH OF ITS TIME TO TREATING DISEASES AND CONDITIONS THAT COULD'VE BEEN PREVENTED OR WHOSE SEVERITY COULD'VE BEEN LESSENED HAD THERE BEEN TIMELY INTERVENTION.

IN 1984, THE LAGUNA RAINBOW CORPORATION COMPLETED A STUDY USING THE DUKE UNIVERSITY-DEVELOPED OARS RESEARCH INSTRUMENT. WE ARE CURRENTLY UTILIZING THAT STUDY TO DETERMINE SERVICE PACKAGES THAT WILL BE NEEDED

BY LAGUNA'S FUTURE ELDERLY. THAT STUDY INCLUDED THOSE BETWEEN THE AGES OF 50 AND 59 AND BY DOING SO, IT PROVIDES A PICTURE OF WHAT THEIR CONDITIONS ARE AND ALLOWS THE CORPORATION TO PROJECT THE RATE OF DETERIORATION OF THEIR FUNCTIONAL ABILITIES. HOPEFULLY, THIS WILL ALLOW THE PUEBLO OF LAGUNA TO BECOME PREPARED TO MEET THE NEEDS OF TOMORROW'S ELDERLY. THIS RESEARCH INSTRUMENT MEASURES THE ELDERLY IN TERMS OF THEIR FUNCTIONAL ABILITY IN THE AREAS OF SOCIAL WELL-BEING, ECONOMIC WELL-BEING, MENTAL WELL-BEING, PHYSICAL WELL-BEING, AND ACTIVITIES OF DAILY LIVING. MR. CHAIRMAN, THIS INSTRUMENT MEASURES THE TOTAL INDIVIDUAL AND HAS BEEN USED IN CLEVELAND BY THE GENERAL ACCOUNTING OFFICE AND THE NATIONAL INDIAN COUNCIL ON AGING ON A NUMBER OF RESERVATIONS ACROSS THE COUNTRY. IN TERMS OF COMPARABILITY, THE STUDIES INDICATE THAT INDIAN PEOPLE AT AGE 45 BEGIN TO EXHIBIT FUNCTIONAL IMPAIRMENTS THAT NON-INDIANS DO AT AGE 65! IN OTHER WORDS, INDIANS "AGE" FASTER AND EARLIER THAN NON-INDIANS. THE STUDY IN LAGUNA UTILIZING THIS SAME SURVEY INSTRUMENT INDICATES THAT THE LAGUNA ELDERLY ARE IN BETTER CONDITION THAN THE TWO POPULATIONS REFERENCED EARLIER. IN TERMS OF MEDIAN SCORES, THE NATIONAL INDIAN COUNCIL ON AGING STUDY WAS 13.5; THE CLEVELAND STUDY WAS 12.0; WHILE THE LAGUNA STUDY WAS 10.5. IN THIS SCORING SYSTEM, A SCORE OF "5" IS EXCELLENT AND A MAXIMUM OF "30" IS TOTALLY DISABLED. I DO BELIEVE THAT THE RESULTS OF OUR STUDY INDICATES THE ADVANTAGES OF PROVIDING A COMPREHENSIVE ARRAY SERVICES TO THE ELDERLY THAT IS DESIGNED TO PREVENT INAPPROPRIATE OR PREMATURE INSTITUTIONALIZATION. NOT ONLY DOES THIS REFLECT IN THE TOTAL WELLNESS OF THE ELDERLY, BUT THE COST OF PROVIDING THESE SERVICES MORE THAN JUSTIFIES THE COSTS OF INSTITUTIONALIZATION. THE CORPORATION, IN 1984, PROVIDED COMMUNITY-BASED SERVICES TO 300 ELDERLY INDIVIDUALS AT A COST OF $5.54 PER PERSON PER DAY. NURSING HOME CARE COST APPROXI-

MATELY $79.00 PER PERSON PER DAY! OBVIOUSLY THE FINANCIAL CONSEQUENCES ARE STARTLING. AS I'VE STATED BEFORE, A LOT OF THESE CONDITIONS COULD HAVE BEEN TREATED AND EVEN POSSIBLY CORRECTED HAD THERE BEEN EFFECTIVE AND TIMELY INTERVENTION.

HEALTH PROMOTION IS A HUMANE AND APPROPRIATE RESPONSE TO THE CONDITIONS OF OUR ELDERLY. OF THE 8,000 INDIAN ELDERLY IN NEW MEXICO, 400 ARE IN NURSING HOMES COSTING AN AVERAGE OF $38 PER DAY OR $5.5 MILLION A YEAR!. THERE ARE AN ADDITIONAL 1,120 WHO ARE CONSIDERED "AT RISK" OF BEING INSTITUTIONALIZED IF SUPPORTIVE SERVICES ARE NOT PROVIDED. IF, MR. CHAIRMAN, ALL OF THESE ARE PUT IN NURSING HOMES BECAUSE OF THE LACK OF SUPPORTIVE SERVICES SUCH AS COUNSELLING, HOME HEALTH CARE, CHORE SERVICES, TRANSPORTATION, MEALS-ON-WHEELS, PHYSICAL FITNESS PROGRAMS, OR TIMELY HEALTH CARE, THE COST OF THIS OVERSIGHT IS $15,534,400.00 A YEAR!

YET, AS WE TALK WITH YOU TODAY MR. CHAIRMAN, TITLE VI OF THE OLDER AMERICANS ACT IS SERIOUSLY IMPACTED BY THE AUSTERITY-MINDED IN THE NATION'S CAPITOL. IN NEW MEXICO ALONE, THE TITLE VI GRANTEES HAVE SUFFERED A $100,000 CUT FROM LAST YEAR'S, ARIZONA GRANTEES HAVE SUFFERED A $100,000 CUT ......HOW CAN WE KEEP OUR ELDERLY WELL WHEN THE VERY PROGRAMS THAT HAVE KEPT THEM FROM ENDING UP IN NURSING HOME ARE BEING CUT? HOW CAN WE KEEP THEM ALIVE AND FULLY FUNCTIONING IN OUR SOCIETY WHEN THE AGENCIES AND DEPARTMENTS THAT ARE, BY LAW, SUPPOSED TO HELP, STAND BY AND SAY THAT IT IS NOT THEIR RESPONSIBILITY?

WE, AS INDIAN PEOPLE WHO WORK AND LIVE FOR OUR ELDERLY, REQUEST THAT THE FUNDS THAT ARE NECESSARY TO IMPLEMENT THE GOALS OF THE

SUBJECT OF THIS HEARING IS A MUST AND NECESSARY ACTIVITY. THE REGIONAL OFFICES OF THE ADMINISTRATION ON AGING RECENTLY NOTIFIED THE STATE OF NEW MEXICO THAT THEY WERE MAKING AVAILABLE $2,000 TO THE STATE TO CONDUCT HEALTH PROMOTION ACTIVITIES. OF THIS, $1,000 IS BEING MADE AVAILABLE TO THE 21 INDIAN TRIBES IN THE STATE. THIS AVERAGES OUT TO $47.62 PER TRIBE!

FINALLY, MR. CHAIRMAN, IN THE RECENT AMENDMENTS TO THE OLDER AMERICANS ACT, THE COMMISSIONER ON AGING INDICATED A COMMITTMENT TO THE ESTABLISHMENT OF A SPECIAL ASSISTANT TO THE COMMISSIONER POSITION THAT WOULD SERVE AS THE INDIAN FOCAL POINT WITHIN THE ADMINISTRATION ON AGING. WE BELIEVE IT IS TIME TO FULFILL THAT COMMITTMENT. IT IS ALSO TIME, MR. CHAIRMAN, THAT THE CONGRESS OF THE UNITED STATES BEGIN ITS EFFORTS TO ESTABLISH AND IMPLEMENT A NATIONAL INDIAN AGING POLICY......AGAIN, A POLICY THAT WAS TO HAVE BEEN DEVELOPED BY THE FALL OF 1982. WE THE INDIAN COMMUNITY HAVE DEVELOPED THAT POLICY. WE BELIEVE THAT THIS POLICY IS NECESSARY TO ENSURE THAT ALL DEPARTMENTS AND AGENCIES OF THE UNITED STATES GOVERNMENT REALIZE IT HAS A RESPONSIBILITY TO MEETING THE NEEDS OF OUR ELDERLY.

IN THIS MANNER, THE ENTIRE HEALTH AND WELLNESS AS DEFINED BY OUR INDIAN PEOPLE, WILL BE MAINTAINED AND STRENGTHENED. OUR INDIAN PEOPLE WILL BE HAPPIER AND ENJOY LIFE IN A FULFILLING MANNER.

THANK YOU MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE FOR THE OPPORTUNITY TO TALK WITH YOU AND SHARE MY THOUGHTS.

Senator **Bingaman**. Thank you very much, Larry, and I gather we have some testimony from Joe Little before we open up to questions here. Joe is with the State Office of Indian Affairs and will be the last witness on this.

STATEMENT OF JOE LITTLE, DIRECTOR, NEW MEXICO OFFICE ON INDIAN AFFAIRS, SANTA FE, NM

Mr. **Little**. Senator DeConcini, Senator Bingaman, Representative Richardson, my name is Joe Little. I am the director for the New Mexico Office of Indian Affairs. I am in a strained position as to what panel to sit on today. We will have the State agencies outlining their area. I did ask to sit on this panel just out of a little bit more comfort because I do have the dubious position of being kind of a liaison between the State agencies and the tribes.

We have prepared some testimony, and we will submit that. This will be very brief, but I think it's an area that hasn't been touched on, and I think it needs to be considered, which is beginning to have some impact in terms of Indian communities it hasn't had in the past and that's the whole prevention area and the health resources area and the services being provided.

There is one big sector or one big gap being left open, and that is there is still very little dialog between the various State agencies and the various Federal agencies that are actually implementing these programs.

In the past we've tended to have Federal agencies consider the tribes as primary responsibilities to them, and they've handled it in that regard.

You then have State agencies coming along and saying, "Well, what's the extent of our responsibilities to the Indian citizens and where do they fall into the Federal programs?"

I think, there is very little dialog that goes on between the State agencies and the Federal agencies to see how these programs could be either melded together or implemented to save funds, prevent overlap, or institute new programs that aren't being instituted because of lack of sufficient funds within a separate Federal and State agency.

For instance, dealing with ambulance services, a lot of the tribal communities need ambulance services as well as some of the smaller community services. We did an innovative process by having the State Corporation Commission allow us to have one of our tribal ambulances issue prepaid insurance to non-Indians as well as Indians so you get a cooperative effort using the health care delivery process.

We've pointed out that a lot of the health prevention area is going to have to be in terms of alcoholism. To do prevention within any area, you're going to have to start at a young age, not at 30, 40 years old.

This means you're going to have to be dealing with public school systems. That's where a lot of the educational and health areas have to be developed. And my concern is that right now every time we get a Federal bill dealing with Indian concerns, there is an automatic shift of either not including the State or having the State go along dealing with other issues.

When you get down to the regulating end is where you lose some of this. I think every time you get a Federal project coming out, you have sessions and sessions within the Bureau of Indian Affairs bringing in tribes, bringing in Bureau people explaining how this is going to operate. But you don't have any sessions going on at the State agencies saying, "That is what we are going to be doing. Are we going to step on anybody's toes? Do you have something that's already on line that can deal with this area?"

So I think there needs to be just a conscious shift within the Federal Government and within the State governments in terms of working a little bit closer together on issues that concern tribal governments because the tribes are tending to be right in the middle of these issues.

And if we're not talking to everybody at the same time, it makes it very difficult to implement the good intentions of any of these bills.

Senator BINGAMAN. Thank you very much, Joe.

[The prepared statement of the New Mexico Office on Indian Affairs, presented by Mr. Little, follows:]

PREPARED STATEMENT OF THE NEW MEXICO OFFICE ON INDIAN AFFAIRS, PRESENTED BY JOE LITTLE, DIRECTOR

The OIA acts as the intermediary between New Mexico's tribes and the state and federal government—as an advocate, a technical assistance center, informational source, and mediator. Thus, it is very interested in matters concerning the health of Native Americans, and the outcome of the Indian Health Care Amendments of 1985.

With last year's Presidential veto of the reauthorization of the Indian Health Care Improvement Act, passage of the Indian Health Care Amendments of 1985 is of vital importance to both New Mexico's Native Americans and Indians throughout the nation. While there have been some significant victories in improving health conditions among Indian people, their health standards still lag far behind the national norms. Nationwide, some 6,000 doctors are needed to provide health care to Indians if Indian health care is to reach parity with the rest of the nation. On the Navajo reservation, the average life span is 42 years, while the national average is 65! One-third of all Indian housing still lacks adequate sewage and water systems, with some 50,000 Indians relying on ditches, hand wells and melted snow for their water source.

Alcohol abuse is a major problem. It is believed that 95 percent of Indians are directly or indirectly affected by a family member's abuse of alcohol. In addition to a wide list of social problems associated with alcoholism, such as broken homes, unemployment and trouble with the law, alcohol is an obvious factor in four of the 10 leading causes of deaths among Indians, namely accidents, cirrhosis, suicide, and homicide. In New Mexico, the suicide rate among Indian males ages 15–34 is seven to eight times higher than the national average! This reflects the wide-spread need for improved mental health programs, as well as alcoholism programs. Motor vehicle fatalities for this same age group are six to eight times higher than the national standards, again a reflection of alcohol problems. And, childhood mortality rates were almost 30 percent higher than the national average over a recent four year period, while effects of Fetal Alcohol Syndrome (birth defects caused by drinking mothers) continue to increase with disastrous results.

Mild to moderately severe nutritional deficiencies also are relatively common among the Indian populace nationwide, especially in infants and preschool children, and women of childbearing age. A problem in itself, malnutrition also contributes to a number of other health problems. A related area, dental conditions, also stands way below national standards. These diet-related disorders tie into larger concerns of Indian health that are beginning to emerge in the 1980s, such as diabetes, heart problems and hypertension. Diabetes has become a serious health problem in recent years, contributing to a rise in blindness and kidney failures among Indians, while hypertension and heart disorder cases are just beginning to increase. Joe Moquino, director of the IHS Santa Fe Service Unit, feels these may be major problems of the future, and that they stem from a change in the eating habits of Indian people. Before, Indians went through feast and famine situations, so their bodies became very efficient at storing food during the good times to carry through the lean times. Now, with food available in relative abundance year-round, Indians are beginning to experience problems in shedding the excess wastes and toxins of modern foods.

While improvements have been made in Indian health, the health status of Indians still lags some 20 years behind the nation, says the IHS. Senator Barry Goldwater noted in a recent speech, "Some critics say there is already a tremendous amount of money going to the Indian reservations. I say those critics should go out to the reservations and see for themselves the unbuilt hospitals, the unclothed and hungry children, the lack of school facilities, and the washed-out dirt roads. In the over 207 years we have had a government, in well over a hundred years of our relationship with our Indians, we have never, I repeat, never lived up the moral obligations we owe these people."

With these problems in mind, the OIA was very pleased to see the drafting of S. 400 by Senator Jeff Bingaman, which provides a new emphasis on prevention of health disorders, and health promotion. The Administration is looking to save funds, and while establishment of preventive programs would initially cost additional dollars, the savings it would soon generate more than compensate. We are very encouraged to see S. 400 has now been incorporated into the larger Indian Health Care Amendments of 1985 bill, and hereby state our support for its passage.

There are few things more basic to life than health. When the federal government entered into treaties with tribes, it often promised to provide health services as a stipulation of the treaties. There is no justification that can deny this obligation, and we urge this committee, Congress as a whole, and the executive branch to recognize this obligation and to continue to address it.

Senator DECONCINI. I have no questions.

Senator BINGAMAN. Congressman Richardson, do you have any questions?

Representative RICHARDSON. Yes, thank you. I can't resist Mr. Little's statement because I think it focuses on what may be the upcoming conflict of this issue in years ahead, and that's budgetary limitations for whatever reason.

Seems to me, and I know you have here three advocates that you don't have to convince about the merits of these programs, but if we're going to be concerned with taking care of Larry's $100,000 that the State has lost, and where's Tom Lujan? Wasn't he right here? And Tom Lujan's very innovative comment and statement about that treatment center in San Juan Pueblo, which I had never heard about, which sounds like a model way and an efficient way to do things. And I know Gilbert Peña has talked to me many times about bureaucracy, about the IHS, or BIA, and the delivery of these programs. Is there a way that we can give health care better delivery under a new bureaucratic structure?

Now, Mr. Little has said the State is completely out of things. And there could be some duplication that could be avoided. I know Gilbert has talked to me many times about BIA accountability on a variety of issues.

The IHS, like any agency, has tremendous bureaucratic problems. Now, I'm asking each one of you here, if we're going to look at improving health care efficiency and delivery, can we change or should we change the bureaucratic structure?

Mr. Little, are we, by including the State in the process, aren't we adding another layer or, perhaps, we should eliminate the Federal role, you know? I'm being very honest and candid. Should there be more direct control by the tribes?

What do we do in this tightening of our belts and the budget where funds will continuously be, I would predict, reduced in the years ahead? How can we improve the delivery, and how can we attain some of these goals?

And I hope you're bold and tell us. Maybe we can do something.

Mr. Little. In fact, I'm saying that the State's done quite a bit considering the lack of direct involvement in the two agencies. What I'm saying is that you can't eliminate either one to where you can't have the State take it over, you can't have the Federal Government take it over. If anybody's going to take it over, obviously, it's going to be the tribes.

What I'm saying is that there's got to be at least at the minimum more coordination, more dialog between the agencies that are handling these areas so that there will be some innovative things coming out of it and they will be able to extend the dollars that are already limited.

A good instance of this is when we had the tribes coming in asking for capital outlay money this time for some of their elderly centers, which are good projects, but it would have helped if they had some Federal backup at the same time working with the State to see about getting this done. If the whole concept had been able to use Federal one-shot money to build the facility and then have the State have some input in maintaining those facilities.

Representative Richardson. Joe, if we did that, wouldn't that save money? Why don't we do that?

Mr. Little. It would. I think it would. Now, you've got a problem in that I know the tribes would be a little bit leery to begin with because you've got a trust responsibility that's locked within the Federal Government, not necessarily with the State. So you don't want to necessarily confuse that issue. OK, that's a main issue that has to be taken care of.

What I'm saying, though, is that it does not eliminate some innovative things going on because some of that money that comes from the State is Federal money anyway. Even though it's earmarked for tribes, it may not necessarily get to them or earmarked for citizens in general doesn't necessarily get to them.

What I'm saying is that it's very imperative that all these agencies start talking together a little bit more to explain what's going on and see if we can't come up with something innovative.

I'm not saying it's going to work overnight, but I think some attempt has to be made; otherwise, we've got a competing force, the Federal Government trying to compete for more bucks to deliver a service, the State trying to get more bucks to deliver a service, and the tribe's getting shortchanged in the middle because neither one has enough money to deliver that service.

Senator Bingaman. Does somebody else on the panel want to comment on Congressman Richardson's question? Yes, Governor, go ahead.

Governor Lucero. I believe in some instances that what is alluded to by Mr. Little works, but not in all cases simply because a lot of the services that are being provided by the State, the Indian people are not—don't get any type of service.

As far as getting more services to the tribes, I believe that if we could work directly between the agency that's providing the funding and the tribes, it would be better controlled by the tribes.

Representative Richardson. So reduce the role of the Federal agency.

Governor LUCERO. Reduce that role because as it is right now, we have so many stepping stones to take before we get our dollars back into the tribes. And I think that this is one of the things that we've said. And it does give us a contract and provision in Public Law 93-638, but at the same time, when we don't go into contracting on Public Law 93-638, then the dollars are cut down. And we can't provide the type of services that we would like to provide. And then they're telling us we're not doing a good job, but how can we when the dollars assigned isn't really there?

And this is what's happening. As a matter of fact, Mrs. Jaramillo has advised me that the present CHR contract that we've got, we have to cut that 2 percent as of right now in order to be in compliance with what Indian Health Service is telling us. And when we cut the budget 2 percent, that just actually means we're cutting services.

Senator BINGAMAN. Gilbert, go ahead.

Mr. PEÑA. I'll hop on the bandwagon with Governor Lucero here on Public Law 93-638. Essentially, I think the spirit of the thing was to give tribes that authority and to give them that flexibility to design programs; however, as we all know, that law has become so burdened with bureaucratic red tape. I think one of the other things that could allow tribes to get better control of some of these programs and sort of eliminate this is that in the contracts and grants or grants or contracts, whatever, is more authority to be delegated to local agencies.

In this case it's the Northern Pueblo Agency and the Southern Pueblo Agency. Right now the tribes submit a contract which goes to the agency. By the time it gets to the area office, half the time they don't have the staff or they're overburdened with work there supposedly that nothing happens for a period of 120 days or 60 days in some cases, and in some cases, paperwork is lost.

The other thing is that budget and planning process that takes place with the Bureau of Indian Affairs is a 2-year process. You start planning now in 1985 for 1987. And by that time, priorities and needs may change within the tribal levels.

Senator BINGAMAN. OK. Let me just ask one question, then we need to get to the final panel before lunch here.

This Zuni Diabetes Prevention Program that you described, Bruce, I was interested in knowing whether your thought is that the reason we're not doing something similar to that in other places throughout the Indian Health Service is because of lack of resources or is it because the policy decision has not been made that that's a good way to deal with that problem?

This is essentially the question that Congressman Richardson asked earlier, is this a problem that we're not—we, the Congress—are not providing enough resources for this kind of a exercise program, which I gather you have designed to deal with this diabetes problem. Is it we're not providing the resources or that the rest of the Indian Health Service doesn't see this as the answer to the problem?

Mr. LEONARD. Well, I don't think it's a question of policy. I think the Indian Health Service is very supportive of these kinds of programs. I think it is a problem of resources. And I think, you know, there are a variety of very innovative health promotion projects that are going on throughout Indian land, you know, as expressed by Tom Lujan's alcoholism program and Larry Curley's elderly program. I think what is needed is the resources to have these kinds of programs doing exactly what you'd like to do, make them model programs where they get the kind of exposure that is necessary so other Indian health services on reservations don't have to reinvent the wheel, that these programs work, to allow these programs to have the kind of support that they can replicate these programs throughout Indian Health Service.

Any one of these three programs can be done in any number of communities throughout the Indian Health, but I don't think—I don't think a lot—I don't think these programs are known by other reservations. And, in turn, if they are made model programs, then I think it's necessary that resources are allowed to support them in terms of doing research to quantify what we're doing and also to allow people like Larry and like Tom are allowed to maybe serve as consultants to be able to share what they're doing right with other Indian health projects.

But I certainly think that resources would be necessary to expand the kinds of demonstrations that exist.

Senator BINGAMAN. OK. I think this has been excellent testimony. I appreciate it very much, and why don't we bring up the final panel before lunch.

Bob McNeil, who is executive assistant to the Governor is, I believe, here to testify. Doctor, did you want to give the testimony for the State, is that—Dr. Kozoll who is the director of the Arizona State Health Department is here to testify. We appreciate him coming in this morning. So why don't the two of you go ahead and present your testimony, and then we'll have some questions, perhaps.

STATEMENT OF DR. RICHARD KOZOLL, MEDICAL PROJECT DIRECTOR, HEALTH SERVICES DIVISION, NEW MEXICO HEALTH AND ENVIRONMENT DEPARTMENT, SANTA FE, NM

Dr. KOZOLL. I am Dr. Richard Kozoll, medical program director for the health services division, New Mexico Health and Environment Department, and it is my pleasure to represent the State of New Mexico this morning. I wish to express Mr. McNeil's regrets at not being here, but I do have a portion of his testimony that he was prepared to present this morning, and would be pleased to present it and answer your questions.

We thank you for giving us an opportunity to testify before the Select Committee in support of S. 400, the Indian Health Promotion and Disease Prevention Act.

Senator Bingaman, we also applaud your emphasis of prevention and promotion. The focus and provisions of that bill emphasize health promotion and disease prevention services as a priority and key strategy for Indian health care delivery.

Three major provisions of this bill address effectively the issues of, one, the need for the development of a health promotion and disease prevention Indian health policy; two, the need to include as a priority, health promotion and disease prevention services within the Indian Health Service, and, three, the need for the continuation and improvement of the Community Health Representative Program as one vehicle to carry out such health promotion activities.

Additionally, this bill calls for the establishment of a demonstration project to develop more cost effective and efficient means of providing health promotion and disease prevention services to Indian people, a measure which could substantially add to our base of knowledge in the area.

S. 400 will be a fitting complement to the health policy of New Mexico. Gov. Toney Anaya set the direction in New Mexico in his first state of the State message when he said:

> Prevention will be a major theme of my administration—the prevention of disease and promotion of good health for all New Mexicans will be a major direction over the next 4 years.

Governor Anaya and the New Mexico Health and Environment Department endorsed the national agenda for health promotion and disease prevention as set forth in the Surgeon General's landmark publication, "Healthy People."

Our agency is strongly committed to programs that promote good physical and mental health habits that may improve mortality and morbidity due to chronic diseases, motor vehicle accidents, suicides, homicides, and other problems that so greatly affect Indian people. It is very tragic to note that out of the 14 leading causes of death in New Mexico standardized mortality ratios reveal Indian mortality to be almost 30 percent higher than the overall U.S. rate.

Even more alarming is the distribution of the causes of death. Four times as many Indians in our State die of accidents as the overall New Mexico population. Twice as many die of diabetes, twice as many of suicide, twice as many of pneumonia, and six times as many die of medical complications of alcoholism.

Particularly tragic is the fact that many of these deaths occur among male children and young adults. Native American male children in New Mexico today have a life expectancy almost 6 years less than the general population.

It is important to note that most causes of excess New Mexico Indian deaths result from unhealthy behaviors and lifestyles. We know that change in many of these unhealthy practices could be the most cost effective and efficient way of improving health status.

For example, much diabetes could be prevented or forestalled by proper nutrition and exercise. Many motor vehicle deaths could be prevented by changes in alcohol consumption patterns and seat belt use.

It is unfortunate to note, however, that we do not yet have the information we need to develop sound prevention programs of this kind in New Mexico Indian communities.

The study and demonstration provided by S. 400 will be of great value in providing information we need. Many agencies currently operate promotion-prevention programs for New Mexico Indian populations. Among them are tribes, the Indian Health Service, voluntary health agencies, school systems, and the State health and environment department.

The need for better coordination between these groups is great. As for the New Mexico Health and Environment, we offer public health services including disease prevention and health promotion in all of our 43 county field health offices.

Nevertheless, many of our most successful efforts on behalf of Indian people have resulted from coordination with or support of Indian Health Service and tribal programs.

A few examples of such interagency efforts are worthy of mention. In September 1983, in conjunction with Indian Health Service pediatricians and community health representatives of the Zuni Blackrock Service Unit, the health and environment department initiated the Zuni Home Injury Prevention Program. A random sample of 365 households was chosen for administration of home hazard surveys as well as for the implementation of environmental changes such as the installment of cabinet-locking devices, insertion of electrical outlet plugs and reducing temperature of hot water heaters.

In addition, outpatient visits for childhood injuries were monitored for the next 9 months. It is hoped that additional interventions for common types of injuries, such as falls and cutting and piercing trauma, will be developed as a result of this surveillance program.

Since the award of Federal Maternal and Child Block Grant Funds to the New Mexico Health and Environment Department over the last several years, emphasis has been placed on supplemental services for native Americans on referral from IHS and tribal programs.

In 1984, for example, over 13 percent of high-risk pregnant women and almost 24 percent of high-risk newborns receiving our specialized services were Indian. Over 540 Indian children with handicapping conditions were participating in our Children's Medical Services Program as of December of last year.

Substance abuse programs targeted at native American youth are currently funded by New Mexico Health and Environment Department at Acoma, Alamo, Canoncito, the Eight Northern Pueblos, Gallup, Mescalero, Cuba, and Taos, all communities with a predominant native American population.

A most exciting recent effort we'll hear more about this afternoon has been joint funding by the Indian Health Service, our department, and the University of New Mexico School of Medicine Pediatric Department to operate a teen center at the Bernalillo schools.

This school district, almost one-half Indian, will have a program of medical care, counseling, and health promotion and disease prevention services easily accessible during usual school hours. Such interagency cooperative efforts as the Bernalillo Teen Center hold great promise for effective and efficient use of resources.

Projects of the kind I have described are worthy initial efforts, but they are not enough. Creative planning and cost-effective resource allocation for promotion and prevention services at the Federal, State, local, and tribal level will be necessary to make a difference in Indian health status. S. 400 points us in the right direction.

Dr. Fitzhugh Mullan, secretary of the New Mexico Health and Environment Department, would specifically like to suggest a badly-needed project which could be one of our first interagency cooperative agreements. The problem is a serious infection which is a major cause of mental retardation, deafness, and death among Indian children. This infection is caused by a bacterial agent, hemophilus influenza. Native Americans are at unusual risk for serious complications of this infection.

There is now available a vaccine from the Centers for Disease Control which can prevent much of the hemophilus influenza meningitis, epiglottis, and other serious invasive forms of this infection that the New Mexico Indian populations suffer from.

The Health and Environment Department has no resources with which to purchase this vaccine, but can lend the support of its field health offices to its administration. A cooperative effort between Indian Health Service and the Health and Environment Department could result in provision of this vaccine to populations at high risk.

Mr. Chairman, thank you for your consideration of our prepared remarks. I would be happy to respond to any questions or comments you might have.

Senator **Bingaman**. Thank you very much.

[Dr. Kozoll submitted the prepared statement of Robert McNeill, executive assistant, Office of the Governor of the State of New Mexico, for inclusion in the record:]

UNITED STATES SENATE
SELECT COMMITTEE ON INDIAN AFFAIRS
MARK ANDREWS, CHAIRMAN

STATEMENT BY Robert Mc Neill
Office of the Governor
State of New Mexico

S. 400 Indian Health Promotion and Disease Prevention Act of 1985

June 1, 1985
Gallup, New Mexico

Mr. Chairman, thank you for giving me the opportunity to testify before the Select Committee on Indian Affairs in support of Senate Bill 400, the "Indian Health Promotion and Disease Prevention Act of 1985" introduced by Senator Jeff Bingaman during the 1st Session of the 99th CONGRESS.

The focus and provisions of this bill emphasize health promotion and disease prevention services as a priority and key strategy for Indian health care delivery. Three major provisions of this bill address effectively the issues of: 1) the need for the development of a health promotion and disease prevention Indian health policy; 2) the need to include, as a priority, health promotion and disease prevention services within the Indian Health Service; and, 3) the need for the continuation and improvement of the Community Health Representative Program as the vehicle to carry out such health promotion activities.

Additionally, this bill calls for the establishment of a demonstration project to develop the most effective and cost efficient means of providing health promotion and disease prevention services to Indian people, a measure that, I am confident, will lead to significant changes producing significant improvement in Indian health for each new generation.

It is very important for this committee to know that Senate Bill 400 will be a fitting complement to the health policy of New Mexico in every respect. Governor Toney Anaya set the direction for health policy in New Mexico in his first State of the State Message wherein he said: "Prevention will be a major theme of my administration - the prevention of disease and the promotion of good health for all New Mexicans."

It is a major policy of this Administration that early intervention in the establishment of health promoting activities for all New Mexicans, as well as early intervention in the detection and prevention of disease, will not only promote a full and productive life, but will also decrease future dependency on the state.

Enthusiastically following the lead of Governor Anaya, The New Mexico Health and Environment Department endorses the national agenda for health promotion and disease prevention as set forth in the Surgeon General's landmark publication, Healthy People. This Agency is strongly committed to programs that promote good physical and mental health habits that are so necessary to change drastically the mortality and morbidity statistics caused by chronic diseases, motor vehicle accidents, suicides, homicides and other causes of death and disability.

Mr. Chairman, we agree with a recent statement by Senator Bingaman that "It is only appropriate that the Indian Health Service, as one of the major federal primary health care providers, also be a part of this movement." A movement that will succeed if the commitment and resources of every level of Government are focused on these major health problems.

What are these major health problems faced daily by the Native American? We only need to review the recent reports of health statistics to gain an idea of these problems and their magnitude.

It is very tragic to note that out of the fourteen leading causes of death for New Mexico Indian residents, Standardized Mortality Ratios reveal Indian mortality to be nearly 30% higher than the overall United States rate. Even more alarming was the distribution of the cause of death. Four times as many Indians died of accidents as the overall New Mexico population; twice as many died of diabetes, suicide and pneumonia; and six times as many died of medical complications of alcoholism. Particulary tragic is the fact that many of these deaths occur among male children and young adults. Native American male children in New Mexico today have a life expectancy almost six years less than the general population.

It is important to note that most causes of excess New Mexico Native American deaths result from unhealthy behaviors and lifeslyles. We know that change in many of these unhealthy practices could be the most cost-effective and efficient way of improving health status. For example much diabetes could be prevented or forstalled by proper nutrition and excercise. Many motor vehicle deaths could be prevented by changes in alcohol consumption patterns and seat belt use. It is unfortunate to note, however, that we do not yet have the information we need to develop sound prevention programs of this kind in Native American communities. The study and demonstration provided by Senate Bill 400 would be of great value in providing the information we need. Many agencies currently operate promotion/prevention programs targeted to at risk New Mexico Indian populations. Among them are tribes, the Indian Health Service, voluntary health agencies, school systems and the State Health and Environment Department.

As for the New Mexcio Health and Environment Department, they offer public health services including disease prevention and health promotion in all of our 43 county field health offices. Nevertheless, many of their most successful efforts have resulted from coordination with or support of IHS and tribal programs. A few examples of such interagency efforts are worthy of mention.

In September of 1983, in conjunction with IHS pediatricians and community health representatives of the Zuni Blackrock Service Unit, the State Health Agency initiated the Zuni Home Injury Prevention Program. A random sample of 365 households was chosen for the administration of home hazard surveys as well as for the implementation of environmental changes such as the installment of cabinet locking devices, insertion of electrical outlet plugs and reducing temperature of hot water heaters. In addition out patient visits for childhood injuries were monitored for nine months. It is hoped that additional interventions for common types of injuries such as falls and cutting and piercing trauma will be developed as a result of this surveillance program.

Since the award of Federal Maternal and Child Block Grant Funds to the New Mexico Health and Environment Department for the last several years, emphasis has been placed on supplemental services for Native Americans on referral from IHS and tribal programs.

In 1984, for example, over 13% of high risk pregnant women and almost 24% of high risk newborns receiving our specialized services were Native Americans. Over 540 Indian children with handicapping conditions were participating in our children's medical services program last year.

Substance abuse programs targeted at Native American youth are currently funded by the New Mexico Health and Environment Department at Acoma, Alamo, Canoncito, Eight Northern Pueblos, Gallup, Mescalero, Cuba and Taos.

A most exciting recent effort has been joint funding by IHS and our Heath Department and the University of New Mexico School of Medicine Pediatric Department to operate a Teen Center at the Bernalillo Schools. This school district, approximately one third Native American, will have a program of medical, counselling, health promotion and disease prevention services easily accessible during school hours. Such interagency cooperative efforts as the Bernalillo Teen Center hold great promise for effective and efficient use of resources.

Projects of the kind I have described are worthy initial efforts, but they are not enough. Creative planning and cost-effective resource allocation for promotion and prevention services at the federal, state, local and Tribal level will be necessary to make a difference in Native American Health Status. Senate Bill 400 points all of us in this direction.

Before I close my testimony, I must bring to your attention a most urgent and recent request from Dr. Fitzhugh Mullan, Secretary of the New Mexico Health and Environment Department. Dr. Mullan states that Indian children must be protected from a very serious infection which is a major cause of mental retardation, deafness and death. This serious infection is caused by Haemophilus influenza and Native Americans appear at high risk from this infection. There is a new vaccine in this country, Haemophilus influenza vaccine, that the Centers for Disease Control recommends using to prevent Haemophilus influenza meningitis and other serious invasive forms of this infection such as epiglottitis.

It is apparent that because of increasing costs of DPT vaccine, there will be no state funds available for the purchase of Haemophilus influenza vaccine. In order to protect Indian children from this serious infection, I urge this Select Committee on Indian Affairs to insure that the federal government provide monies directly to the Indian Health Service for the purchase of this vaccine according to CDC recommendations. Your urgent attention to this request would be greatly appreciated.

Mr. Chairman, thank you for your consideration of my comments. I will be happy to respond to any questions or comments.

Senator BINGAMAN. Dr. Novick, we appreciate your coming today to the hearing. Go right ahead with your testimony.

PREPARED STATEMENT OF DR. LLOYD F. NOVICK, DIRECTOR, ARIZONA DEPARTMENT OF HEALTH SERVICES, PHOENIX, AZ

Dr. NOVICK. Thank you. I am Dr. Novick, and I'm director of the Department of Health Services in Arizona. I have some copies of my testimony, which I will leave with you.

Basically, I come here today to testify in support of S. 400, the Indian Health Promotion and Disease Prevention Act of 1985.

The health status of Indians living on reservations in Arizona is still significantly below the health status of the remainder of the population. One of the areas of particular importance that I'll talk about today is with respect to pregnancy outcomes. The secondary is with respect to adult health prevention.

With respect to factors influencing pregnancy outcomes, about 8 percent of pregnant women in Arizona as a whole had an inadequate number of prenatal visits; that is, less than four prenatal visits in 1983. And that number should have been less.

Yet on the Navajo Reservation, that percentage of inadequate prenatal care is 19 percent. On the Hopi Reservation, it is 21 percent, and at Fort Apache, it is 22 percent.

There are unsatisfactory outcomes because of that. Less prenatal care translates into—is a major risk factor for low birth weight, which in itself is the major risk factor for infant death and problems with newborns; 10 percent of all low-birth-weight babies in Arizona, babies less than 5½ pounds, were born to Indian mothers.

The Indian fetal death rate was also higher. And there was a strikingly higher rate of congenital anomolies of 13.8 per 1,000 live births, more than 50 percent higher than the rest of the population. And part of that is connected with prenatal care. Part of that is created with alcohol use during pregnancy.

Two things are needed. First, there needs to be better organization of prenatal care services that are available and resources for those services. But, in addition, there must be work in outreach and education to convince pregnant women about the importance of this type of care as well as the importance of other preventive health measures to follow during pregnancy.

Family planning is also a program related to this. A major concern from a health point of view is the fact that of births to mothers under age 15 in Arizona, 27 percent are Indian.

Return to adult health, adult health promotion, there is a lot of interest now in prevention across the Nation. There are new technologies in prevention being termed communitywide health prevention. They use media and use school classrooms in different ways than have been used before.

And I think that health promotion in the area that we're interested in today should follow those models, but also needs, of course, to be tailored to the unique aspects of the health problems that we see on reservations and among native Americans.

It's of interest to compare the leading causes of death among the population as a whole. The heart disease is first followed by cancer, stroke, and accidents; whereas, in the native American population, accidents is the first and then followed by heart disease. Any prevention program must take this into account.

Alcohol abuse is a risk factor here. It has been testified to by other speakers. Other lifestyle factors are important. I should point out that because there is a lack of such services in Arizona, a lack of such services offered by the Federal Government level, in one of the questions that was raised earlier, we contract directly with three tribes so that they can provide alcohol, drug, and mental health services.

Diabetes has been mentioned here before as a common problem. I would like to tell you about an effort that we are engaged in with respect to this problem in a project with the Gila River Indian Reservation.

Since 1980, we have contracted with the Indian community. The objectives are to reduce diabetes by a preventive program. We have made some progress. A tribal health unit has made progress in conjunction with the service unit, and have effectively demonstrated a reduction in blood sugar levels, and in weight, and an increase in physical fitness. These successes were accomplished through an organized effort in education, lifestyle counseling, and physical fitness programs.

I would like to now address the three major provisions of the proposed act, which are planning, demonstration projects, and community health representative training. We support planning. We have established a public health agenda for the year 2000 with specific objectives that we want accomplished.

This planning was done in collaboration with representatives of Indian tribal governments. We also support the demonstration projects. I feel that our State could provide a good site for such a demonstration project. And, third, in terms of community health representative training, we have already established local public health in-services in which both tribal and Indian Health personnel may participate and will be most interested in working additional training activities such as this act indicates.

And that ends my comments.

Senator BINGAMAN. Thank you very much.

[Dr. Novick's prepared statement, on behalf of the Arizona Department of Health Services, follows:]

ARIZONA DEPARTMENT OF HEALTH SERVICES
Office of the Director

BRUCE BABBITT, Governor
LLOYD F. NOVICK, M.D., M.P.H. Director

TO: Select Committee on Indian Affairs
United States Senate
99th Congress, 1st Session

DATE: May 29, 1985

RE: Testimony for the Congressional Record on S. 400
"Indian Health Promotion and Disease Prevention Act of 1985"

TESTIMONY BY: Lloyd F. Novick, M.D.
Director, Arizona Department of Health Services

On behalf of the State of Arizona's Department of Health Services, I welcome this opportunity to testify in support of Senate Bill 400, the "Indian Health Promotion and Disease Prevention Act of 1985."

There are twenty Indian reservations in Arizona, and three Area Indian Health Services. The total enrolled population on reservations is approximately 163,000, and represents about 5.6% of Arizona's population.

Though improving, the health status of Indians living on-reservation is still below the health status of the general population. The birth rate for Native Americans in Arizona is higher than the State average, and fewer Indian women receive adequate prenatal care. For example, 7.9% of all pregnant women delivering in Arizona in 1983 had 0-4 prenatal visits. Yet, on the Navajo reservation, that percentage of inadequate prenatal care, as defined by zero to four visits, was 18.8%. On the Hopi reservation, it was 21%, and on the Fort Apache, 22%.

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Other birth data indicates that 9.2% of all low birth weight babies, defined as less than 5½ pounds, were born to Indian mothers. The Indian fetal death rate was 9.4 per 1,000 live births, as compared to 7.4 for all other races. In addition, the rate of congenital anomolies for Indians was 13.8 per 1,000 live births, as compared to a total for all races of 8.8.

Clearly, the need for early and continuous prenatal care on-reservations is evident. The clinical systems for prenatal care through the Indian Health Service Units are in place. In addition, the Indian Health Services utilizes the State's regionalized perinatal and neonatal transport and care systems.

What appears to be lacking in reservation prenatal care are concerted efforts in outreach and education. The Arizona Department of Health Services has initiated some action to help address these gaps. For example, negotiations for an Intergovernmental Agreement are underway with the Navajo Nation to augment the community health representatives program for prenatal education and outreach. Consultation and technical assistance by a maternity nursing consultant and health educator are being provided to the San Carlos Tribe and Service Unit.

Family planning programs, with a major focus on education, are also evident in need. In 1983, 23.2% of all births to unwed mothers in Arizona were to Native Americans. Of major concern, however, is the fact that of births to mothers under age fifteen, 26.8% were Indian. These fourteen year olds and younger are still children themselves.

The five leading causes of death for Arizona's general population are heart disease, cancer, stroke, accidents and chronic obstructive pulmonary disease. For Arizona's Indians, however, the leading cause of death is accidents, followed by heart disease, cancer, ill defined conditions, and pneumonia and influenza.

Alcohol abuse and alcoholism on-reservations, which is generally known to be a significant problem, is likely a major contributing factor to the high accident mortality rate. Other lifestyle factors may also contribute. The Arizona Department of Health Services currently contracts directly with three Tribes for alcohol, drug, and mental health services. In addition, such services are provided to other reservations through Department contractors. The Department is continuing its efforts to identify additional needs and resources for prevention and intervention of alcohol, drug, and mental health problems on reservations.

Of interest is a fairly low ranking for chronic obstructive pulmonary disease as a cause of death among Arizona's Indian population. I have been told, however, that cigarette smoking is not as common with Native Americans as with the general population.

Diabetes is a prevalent chronic disease for Arizona's Indians, and accounts for a significant portion of outpatient visits for Indian Health Services. One of the consequences has been a high number of Indians with end stage renal disease, requiring expensive dialysis treatments for a primarily rural population.

Though considerable research and intervention efforts have been directed toward diabetes among Indians, I would like to draw attention to a successful project on the Gila River Indian Reservation. Beginning in fiscal year 1980-81, the Arizona Department of Health Services has contracted with the Gila River Indian Community to reduce diabetes and its consequences. Tribal health employees, in conjunction with the service unit, have effectively demonstrated a reduction in blood sugar levels and in weight, and an increase in physical fitness. These successes were accomplished through an organized effort in education, lifestyle counseling, and physical fitness programs.

I could continue to cite various other Indian health status indicators on chronic and communicable diseases, as measured by Arizona's vital statistics and morbidity data. However, a brief summary of other collaborative activities between Tribes, Indian Health Services, and the Arizona Department of Health Services should suffice.

The Department provides consultation and technical assistance in the area of communicable disease control, such as sexually-transmitted diseases and plague. In addition, funding is provided to three Tribes for tuberculosis control. State purchased vaccines for diptheria, pertussis, tetnus, polio, measles, mumps, and rubella are provided for all public schools on reservations. Finally, some assistance is also provided by the Department's Environmental Health Division for air and water pollution and waste control.

I would like to now address the three major provisions of the proposed Act, which are planning, demonstration projects, and community health representative training in health promotion and disease prevention.

Recent health planning efforts by the Arizona Department of Health Services to establish a Public Health Agenda for the year 2000 have included Tribal participation. Planning for Indian health promotion and disease prevention would be supported by the Department as an active participant in any collaborative effort.

The State also supports demonstration projects in effective, cost-efficient and culturally appropriate health promotion and disease prevention services. I would suggest that Arizona would provide a likely site for such a demonstration project, given its large Indian population and established collaborative efforts to date.

The Arizona Department of Health Services could also assist with Community Health Representative training programs. The Department has already established regional local public health inservices, in which Tribal and Indian Health personnel may participate. Additional training activities could be made available through coordinated efforts with Indian Health Services and Tribal health personnel.

Senator **Bingaman**. Senator, go right ahead.

Senator **DeConcini**. Thank you, Senator Bingaman. Dr. Novick, you mentioned a number of initiatives where there are joint State-tribal activities taking place in the health promotion in your statement I've just looked at.

How does the State fund its share of the program? Is that through direct State funds, or is that block grant money from the Federal Government, or a combination, or do you know?

Dr. **Novick**. For the most part, almost exclusively these are Federal block grant funds, and we are devoting an increasing percentage of the preventive health block grant and also mental health and drug abuse grant in establishing agreements with the various tribal governments.

There have been some State moneys used in one particular prenatal education effort, but the rest have been Federal moneys.

Senator **DeConcini**. How much funding is provided by the State for health promotion and disease prevention activities, do you know?

Dr. **Novick**. Well, health promotion and disease prevention activities is a very wide—covers a very wide scope of things, and I have not added it up, but I should, and I will because it's an interesting question. You have to add in immunization, sexually transmitted disease——

Senator **DeConcini**. Can you answer that?

Dr. **Novick**. And that can and should be ascertained. The bulk of the preventive health activities that this bill addresses are really similar to the preventive health block grant of which we get $1 million. But many millions of dollars, if you added—depending on what you call prevention—would be applicable, and I will get that number for you.

Senator **DeConcini**. Thank you very much. That is all I have. Thank you for being here, doctor. We appreciate your traveling here and taking part today.

Senator **Bingaman**. Let me ask either one of you that would like to to just respond here. From the little I know about the way we deal with health care and education, it strikes me that we organize State government and the Federal Government and, really, all government sectors on the lines that one department will deal with health and another will deal with education, and when you get to the subject of preventive health, or disease prevention, or health promotion, we always seem to do less than we should because the health people don't feel that it's really their job to educate the youth through the schools on health matters, and the education people have a lot of other things they're responsible for, and health comes up last.

I would be interested in your comment as to whether there's sort of a structural bias against using our public school system or our school system in general to provide some of the information and education that's needed to deal with these problems to youth.

Dr. **Novick**. Yes; I think there is a structural bias. I think it can be overcome with great effort. I think if you're going to change lifestyles and behavior, you obviously have to begin with children, and the younger you begin, the better, even going down as far as preschool.

Yet, in addition to some of the communication problems you mentioned, schools may, with a great deal of merit, see their primary role as instruction in reading or writing, and health matters are not as important. In the State I worked in previously to this, we were able to get an alcohol prevention program in the schools, in the elementary schools, and also use the media, use Saturday morning cartoons to try to do this. We did get cooperation.

One of the things that strikes me is the fact that there is a technology to reduce smoking among junior high school students. It doesn't consist of a teacher standing up in front of the classroom saying, "Don't smoke." It has to do with other types of methods, interaction among peers showing smoking is unattractive. It has been used in some States.

We surveyed 1,000 Arizona schools and found out that this technique was not being used. Using the preventive health block brand moneys and working with the Department of Education in Arizona, we are making some progress, too, in starting a program next year. But it is very difficult to meld those two organizational structures.

Senator BINGAMAN. Dr. Kozoll.

Dr. KOZOLL. I agree with Dr. Novick. I think there is a structural bias in much of what we do in the promotion and prevention area. I think it's, perhaps, even stronger in broad medical care systems such as the Indian Health Service or the Veteran's Administration where the curative aspect of care tends to dominate both the time and the dollars available for health care.

I think we've made progress in recent years in breaking down some of those barriers in New Mexico. And, in fact, I can think of a number of cooperative projects that we now have in place between school nurses and public health nurses of our field health offices of the Health and Environment Department.

I think part of the answer here has to do with regular communication at the local level and at the State level. I think that it's not an uncommon situation for a school nurse and a public health nurse in a relatively small community of our State to get together and to say to each other: "Well, I didn't know you were doing that. Well, I didn't know that was going on in school." You know, that sort of phenomenon happens all the time, and I think we're dealing in part with a communication problem, the remedy of which could bring us a long way toward breaking down some of these barriers. But I think you have a good point on how we're structured in terms of promotion and prevention services.

Senator BINGAMAN. OK. Thank you very much for that testimony. Our plan is to go out and recess now until 1 o'clock, at which time we'll have some testimony from the Deputy Director of the Indian Health Service. And we hope all of you can come back at that time. Thank you.

AFTERNOON SESSION

Senator BINGAMAN. OK, why don't we get started again. Doctor Ivey is going to be the leadoff witness. He is the Deputy Director of the Indian Health Service in Washington, and we appreciate your being here, Doctor.

Why don't you—let me just identify who I believe your colleagues are, and if I miss anybody, then just correct me. Dorothy Gohdes is here, who is the Acting Director of the Central Diabetec Program for the Indian Health Service in Albuquerque. Charles Reaux, is that the correct pronunciation, who is the chief of occupational health and injury for Navajo area in Window Rock.

Gordon Jensen, who is the chief—Gordon is chief program planning and evaluation in Phoenix, the Phoenix area Indian Health Center. And Josephine Waconda, chief of preventive health branch in the Albuquerque area Indian Health Service in Albuquerque. And Michael is here again, and we appreciate him being here. So go right ahead, Doctor, we appreciate your testifying here.

STATEMENT OF GERALD IVEY, DEPUTY DIRECTOR, INDIAN HEALTH SERVICE, WASHINGTON, DC, ACCOMPANIED BY JOSEPHINE T. WACONDA, CHIEF, PREVENTIVE HEALTH BRANCH, ALBUQUERQUE AREA INDIAN HEALTH SERVICE, ALBUQUERQUE, NM; GORDON JENSEN, CHIEF, PROGRAM PLANNING AND EVALUATION, PHOENIX AREA INDIAN HEALTH CENTER, PHOENIX, AZ; CHARLES REAUX, CHIEF, OCCUPATIONAL HEALTH AND INJURY FOR NAVAJO AREA, WINDOW ROCK, AZ; DR. DOROTHY GOHDES, ACTING DIRECTOR, CENTRAL DIABETIC PROGRAM, INDIAN HEALTH SERVICES, ALBUQUERQUE, NM; AND MICHAEL LINCOLN, AREA DIRECTOR, NAVAJO AREA INDIAN HEALTH SERVICE, WINDOW ROCK, AZ

Mr. IVEY. Thank you, Senator Bingaman, Mr. Chairman. I am Gerald Ivey, the Deputy Director of the Indian Health Service. You've introduced the people that are here with me.

It is a pleasure to appear before you today to discuss health promotion and disease prevention needs within the Indian community——

Senator BINGAMAN. Let me just interrupt a minute. I think the people in the back are having great difficulty hearing, is that right? If you could speak up, that would be great. And let me just suggest that any of you who really want to hear might just move down here. That would help quite a bit.

Mr. IVEY. Is this working at all?

Senator BINGAMAN. I'm not sure. Why don't you tap it? I guess it's working a little bit, if you want to really hold it an eighth of an inch from your mouth.

Mr. IVEY. It's a pleasure to appear before you today——

Senator DECONCINI. Now you got it.

Dr. IVEY [continuing]. To discuss health promotion and disease prevention needs within the Indian community and how the Indian Health Service has and continues to address these needs.

The provision of high quality prevention services has alway been of the highest importance to the IHS. Its been clearly demonstrated in the many preventive activities that are well-documented in the history of IHS.

I would like to offer only a few examples that have had substantial impact on the health of American Indians and Alaskan Natives.

Perhaps the most enduring contribution to prevention services made by IHS has been the provision sought in liquid waste management and clean water. This activity has contributed to the health and welfare of the IHS service population in many ways.

Not only has the number of childhood illnesses due to waterborne disease diminished, but the increase in healthful lifestyles and attitudes has been most impressive.

Immunization activity has also been a mainstay of the preventive services provided by the IHS. The effectiveness and acceptability of this approach to disease prevention is well-documented.

In 1984 the percentage of children with age appropriate immunization in the IHS service population was 90 percent. This also has had a positive impact on the morbidity and mortality in the children cared for by the IHS.

The CDC, center for disease control, has worked formally and informally over the years with the Indian Health Service in the field of health promotion.

This collaboration is increasing, and we view them as a valuable partner in our effort. You've heard this earlier, about the scurge of diabetes, and with us today is a medical expert in that field, Dr. Dorothy Gohdes.

I could mention many other activities in preventive health in the Indian Health Service, but rather than do that, I would like to submit for the record a copy of the plans from Albuquerque, Phoenix and Navajo in preventive health as an example of what's happening in the Indian Health Service. We have similar plans from the various areas.

Rather than use our limited time for me to read more of the prepared text which you have access to, I would like to make this time available for your questions and the rest of the witnesses.

S. 400 contains a statement of goals which we support. We testified to that effect at the hearing on S. 277, the Indian Health Care Improvement Act reauthorization bill, which contains many of the provisions found in S. 400. We will be happy to answer your questions.

[Mr. Ivey's prepared statement, with attachments, on behalf of the Indian Health Service, follows. Text resumes on p. 181.]

PREPARED STATEMENT OF DR. GERALD IVEY, DEPUTY DIRECTOR, INDIAN HEALTH SERVICE, WASHINGTON, DC

Mr. Chairman, Members of the Committee and Senator Bingaman:

I am Mr. Gerald Ivey, Deputy Director of the Indian Health Service (IHS). With me are Mr. Michael Lincoln, Director, Navajo Area Office; Dr. Dorothy Ghodes, Acting Director, Central Diabetes Program; Mr. Bruce Leonard, Health Educator, Zuni Service Unit; and Mr. Charles Reaux, Chief, Occupational Health and Injury Control Branch, Navajo Area.

It is a pleasure to appear before you today to discuss health promotion and disease prevention needs within the Indian community and how the Indian Health Service has and continues to address these needs.

The provision of high quality prevention services has always been of highest importance to the IHS. This has been clearly demonstrated in the many preventive activities that are well documented in the history of IHS. I offer only a few examples that have had substantial impact on the health of American Indians and Alaska Natives.

Perhaps the most enduring contribution to prevention services made by the IHS has been the provision of solid and liquid waste management and clean water. The President's 1986 budget proposes transferring responsibility for the construction of sanitation facilities away from the IHS, to permit the IHS to focus on health delivery as opposed to construction. This activity has contributed to the health and welfare of the IHS service population in many ways. Not only has the number of childhood illnesses due to water-borne disease diminished, but the increase in healthful lifestyles and attitudes has been most impressive.

Immunization activity has also been a mainstay of the preventive services provided by the IHS. The effectiveness and acceptability of this approach to disease prevention is well-documented. In FY 1984 the percentage of children with age appropriate immunization in the IHS service population was 90%. This also had a positive impact on the morbidity and mortality in the children cared for by IHS.

The Centers for Disease Control (CDC) has worked formally and informally over the years with the Indian Health Service in the field of Health Promotion. During the Health Education-Risk Reduction Grants Program, 1979-1981, some 5% of the programs receiving grant support for alcohol or tobacco programs addressed the needs of Native Americans. Ongoing technical and programmatic consultation is provided to the IHS regional health education specialists, who are also attending the annual Health Education-Risk Reduction meeting of The Conference of State and Territorial Directors of Public Health Education, at CDC, in Atlanta this year.

Various tribal groups have participated in and are contributing surveillance data for the national nutrition surveillance system. In addition, the IHS is invited to contribute program descriptions and to retrieve similar data on health promotion projects from CDC's computerized health education data base.

In April 1984, at the invitation of the IHS and the Bureau of Indian Affairs, CDC staff showcased the Teenage Health Teaching Modules (THTM) and provided information on the School Health Curriculum Project (SHCP) to over 600 representatives of the National Indian School Board at its annual meeting in

Phoenix, Arizona. A primary objective was to provide school board members with the information and tools necessary to effectively carry out their roles as policymakers and to clearly understand their responsibility under P.L. 95-561. Prior to 1979, Bureau of Indian Association School Boards were advisory or, in many cases, nonexistent regarding the education of their children. Under P.L. 95-561, Indian school boards have new powers governing policy to foster Indian control in all matters related to education. Broad scale acceptance and implementation of the THTM by Indian School Boards can have significant impact on the health behavior of Native American youth, in that it addresses such areas as nutrition, substance use and abuse, injury prevention, mental and emotional health, and stress.

CDC has recently launched a program to provide communities with hands-on assistance for assessing significant health problems, setting community objectives for risk reduction programs, and developing and implementing appropriate interventions. The process and materials involved in this Planned Approach to Community Health program will be available to the IHS, and should prove uniquely helpful in addressing priority health problems.

CDC has been involved in long-standing relationships with States in a number of disease prevention programs which include areas served by the Indian Health Service. These programs are directly related to the listing of Disease Prevention areas mentioned in S. 400, namely; immunizations, control of high blood pressure; control of sexually transmittable diseases; family planning;

pregnancy and infant care; control of toxic agents; occupational safety and health; control of accidental injuries; fluoridation of water; and, control of infectious agents.

Aggressive prevention approaches have also been utilized in addressing maternal and child health related to perinatal issues. Community outreach including early case-finding and health education concerning pregnancy and child care have paid significant dividends. In 1956 the infant mortality (deaths during the first year of life) was 55 deaths per 1000 live births. In the three year period 1980-82 the infant mortality was 11.6 deaths per 1000 live births. These most recent figures are the same as those for the general U.S. population. Impressively the neonatal rate (deaths between birth and 28 days of life) was much lower than the general population. Prevention services have been most useful in this area.

Contemporary epidemiology has identified new challenges for IHS. Today, diabetes mellitus is a scourge affecting Indian people. In the U.S. population as a whole, diabetes affects 1 person in 20, but for Indian people it strikes 1 in 5. If one is a Southwestern Indian it is even more prevalent in that the disease affects 1 in 3 individuals.

Alcohol abuse and other chemical abuses contribute to four of the top ten leading causes of death. If you are an Indian in the United States your odds of dying prematurely from alcohol related death are much higher than if you are a non-Indian. This includes deaths related to suicides, homicide, accidents and injuries and alcoholic end-stage disease.

The IHS is committed to maintaining a balanced delivery of acute and prevention services that addresses the disease entities afflicting Indian people. This is demonstrated by the activities of many of our Service Units but perhaps nowhere more dramatically than right here in western New Mexico at the Zuni Comprehensive Community Health Center.

At Zuni the problem of diabetes has been attacked through a multidisciplinary effort spearheaded by the Service Unit health educator. This activity has focused primarily on fitness and self-care. It has had a high degree of success with 20 people able to cease the use of insulin while returning to normal blood sugar levels. Other patients are expected to have the same outcome as the program progresses. In addition, the rate of alcohol and chemical abuse appears to be decreasing. The community has taken ownership of the process and the mental health of the community appears to be improving. A more detailed description of the Zuni experience is attached. Also attached are descriptions of current health promotion disease prevention activities being carried out in the Phoenix and Navajo Areas. Finally, a brief profile is attached of the Navajo Area's health promotion and disease prevention status.

The IHS is seeking ways to actively replicate this process. The health future in Zuni and other Indian communities will depend upon the degree to which IHS is able to proliferate these activities and most importantly to cultivate a sense of community ownership of the plan and implementation of prevention services.

The above discussion indicates in a small way the IHS commitment to health promotion and disease prevention. S. 400 contains a clear statement of policy and goals which we support. We testified to that effect at the hearing on S. 277, the Indian Health Care Improvement Act reauthorization bill, which contains many of the provisions found in S. 400. But as we previously testified, we oppose those S. 400 provisions which provide for an extensive system of reports, regulations and tribal plans which we believe would divert scarce resources from health promotion and disease prevention services. In addition, S. 400 would authorize $500,000 for an unecessary demonstration authority and requires IHS to maintain the Community Health Representitive Program, neither of which are included in the President's budget.

I will be happy to answer any questions which you may have.

Zuni Service Unit Diabetes Program

In the last forty years, the prevalence of Type II diabetes on Indian reservations has evolved from a rarity to a full blown epidemic. The average white American has a one in twenty chance of developing diabetes. The odds among American Indians are one in four. Here in Zuni, it is estimated that one out of three adults over the age of thirty-five will develop the disease.

Diabetes is a chronic, metabolic disorder which affects the body's ability to metabolize food into energy. Among type II diabetics, there are not enough insulin receptors in the cells to absorb all the glucose (sugar) which is produced. The unused glucose accumulates in the blood to unhealthy levels. This in turn leads to complications.

In 1971, 55,000 outpatient visits to Indian Health Service clinics nationwide were attributed to diabetes. In 1983, this number soared to 154,000. Diabetes was the leading reason for outpatient visits in Zuni last year. In 1973, there was one case of kidney failure, or end-stage renal disease, in Zuni. In 1984, there were twenty cases, resulting in a cost to the service unit of $500,000, or $25,000 per patient. Other complications attributable to Type II diabetes are: retinopathy, strokes, coronary disease, and nerve damage. These complications are occurring at an accelerating rate and will continue to be more costly to the IHS system.

The encouraging news is that Type II diabetes is a disease that can be prevented and easily controlled. Doctors have always known that obesity increases the risk of developing Type II diabetes. Now they also know that weight loss somehow reduces blood-sugar levels by increasing the number of insulin receptors.

The Zuni Diabetes Project has been in operation since July of 1983. It is an exercise/education program which consists of five aerobic exercise classes a week. The classes are between 45 minutes to 60 minutes in length and include exercises choreographed to popular music. These exercise classes are supplemented by educational classes which provide information about physiology, nutrition, exercise and other diabetes related topics.

Over two hundred Zunis have participated in these classes. Fifty of these individuals have experienced an average weight loss of fifteen pounds. Twenty diabetics have been taken off insulin and now record normal blood sugars. Since all Zunis are at risk of developing Type II diabetes, this class provides both primary and secondary prevention. Those Zunis who participate and lose weight through exercise decrease their chances of ever developing diabetes. Those who have diabetes, that exercise and lose weight can often control their blood sugars without medication and prevent possible complications in the future.

This class has served as catalyst to the development of other aerobic classes and fitness activities in the Zuni Community. When this class started in July of 1983 there were two other weekly community aerobic classes available. As of May 17, 1984, forty-six aerobic classes are available weekly in Zuni. Many of those classes are being conducted at worksites by the largest employers in Zuni. Nine exercise classes a week are offered to hospital employees at the Zuni Indian hospital. Five classes a week are offered for tribal employees. Daily classes are available at three different school sites. In addition to these worksite locations, aerobic exercise classes are also offered to special population groups such as three classes a week to senior citizens and three a week for substance abusers. Most of these classes are conducted by volunteers. Classes are offered every evening and on weekends for anyone in the community that is interested in participating.

The Zuni Fitness Series is in its second year. It consists of five monthly road races which, last summer, attracted 1,200 participants. Each event includes a 2 mile non-competitive fun run/walk along with a variety of other competitive distances.

These activities not only serve to prevent/control diabetes, but effectively prevent heart disease, stroke, gall bladder disease, some forms of cancer and a wide range of other obesity related diseases. Increases in physical activity can also serve to promote health. As an individual's self image improves with the loss of weight and increased energy, there can be a decrease in the dependence on alcohol and drugs. The Zuni hospital exercise program has demonstrated at 27% decrease in absenteeism for those participating employees.

IHS Phoenix Area Disease Prevention and Health Promotion Activities

A review of disease patterns in relation to funds expended confirmed our assumptions that in the past ten years, patterns of illness had changed from acute infectious diseases to health problems associated with lifestyle. A large portion of the annual budgetary allocation to the Phoenix Area IHS is expended upon diseases and health problems associated with obesity, poor nutrition, a hazardous environment, smoking and substance abuse and lack of fitness. We determined that to continue the long-term expenditure of large sums of federal funds on diseases either caused in large part or severely aggravated by unhealthy lifestyles required a strong and focused public health approach. If individual community and commercial values encourage "junk food" diets and poor nutrition, no exercise, use of tobacco and abuse of substances such as alcohol; and these values strongly influence the onset of such major health conditions as diabetes, high blood pressure, coronary artery disease, lung cancer, emphysema and the multitude of adverse health conditions prevalent with substance abuse; then, we determined to develop intervention, educational and prevention techniques to change lifestyles.

The health staff of several tribal health departments and the IHS staff, frustrated by years of witnessing fine people lose their health to unhealthy lifestyles, found a new enthusiasm in their work by concentrating on emphasizing wellness. This was the origin of Phoenix Area's Health Emphasis Campaign (H.E.C.). The campaign is scheduled to extend through 1990.

The planning process has centered around the U.S. Public Health Service's "Promoting Health/Preventing Disease: Objectives For The Nation" and the 15 health promotion/protection and disease prevention areas identified in S. 400, "Indian Health Promotion and Disease Prevention Act of 1985" with slight local modifications. Because of the extremely high incidence of non-insulin dependent diabetes mellitus (NIDDM), this specific entity was included in the category with "control of high blood pressure." A recent non-published, retrospective study at one of our service units indicated that high blood pressure was invariably associated with either NIDDM or obesity. Therefore, "improvement in nutrition" was incorporated with "control of obesity."

In 1985, the Phoenix Area published a five-year Health Promotion/Health Prevention Plan which identifies the same Health Prevention/Health Promotion initiatives identified in S. 400. The Plan outlines goals and objectives for each initiative and is utilized by our service units as a guide in developing specific health programs and policies. We strongly advocate this type of health service and have an equal commitment to the premise that all people should be educated to the point of making informed decisions about how they can take an active role in their own care and treatment. The Phoenix Area has been very active in its efforts to make people better informed. Since our five-year plan was implemented, we have identified IHS and Tribal Coordinators in each of our ten service units and have made them responsible for reporting quarterly on the implementation and evaluation of the 15 health plan initiatives.

In 1985, all ten of our service units incorporated two or more of these health care initiatives into their Annual Emphasis Plans. Each initiative that is addressed is in response to specific health needs of the Indian tribes being served by the service unit. The following is a compilation of the currently available, Health Promotion/Health Prevention resources provided to the Indian communities within the Phoenix Area. This overview gives some perspective of the various health care needs and problems prevalent within the Indian population groups.

Accident Prevention/Injury Control

1. Six service units have implemented an Infant/Child Restraint Program in response to the State laws requiring the use of devices to restrain children under five years of age.

2. In the Phoenix Area, injuries rank second as the major cause of hospitalization. Service units are addressing this problem by promoting safety and reducing morbidity and mortality associated with accidents by taking action in the areas of animal control, pest control and community injury control.

Occupational Safety

Institutional Environment Control programs are being developed to deal with the safety of hospital employees and community residents. These programs investigate accidents, survey hazardous environmental contaminants, and provides technical assistance for occupational safety or exposure to toxic agents in the reservation community.

Alcohol

Concentration of alcohol activities are in the areas of community and classroom education, encouraging law enforcement efforts, developing tribal program packages for service to deal with substance abuse, Fetal Alcohol Syndrome awareness, and resource availability.

Stress

Service units are redefining and expanding mental health projects for the community as well as employees through suicide prevention, stress management, reducing obesity and aerobic activities.

Diabetes/Hypertension

In conjunction with Diabetic Clinics, patient education sessions are held which emphasize diet, exercise and preventing diabetic complications according to accepted protocol. The goal is to educate diabetics so that they take better care of their chronic conditions and to inform/educate their relatives and friends on how to avoid becoming a diabetic and/or how to take control of their condition and learn to live a lifestyle that is not so restricted.

Family Planning

Emphasis in family planning is being placed in the areas of prenatal teaching, parenting education, increasing the rate of breast feeding, proper nutrition, birth control counseling and sex education in the schools.

Immunization

Infant immunization programs are in place in all of the service units and efforts are being made to increase the rate and improve reporting through more comprehensive surveillance.

Special attention is also being given to immunizing adult diabetics and other high risk patients.

Infant Health

Within this initiative, the service units are concentrating on improving patient education and patient surveillance for a more comprehensive documented program of well child care. This includes maintaining and improving the current surveillance program for Otitis Media.

Fitness and Exercise

Employee and community wellness programs are being initiated which include health risk appraisals and aerobic classes.

At Keams Canyon, the medical staff has developed guidelines on adult health maintenance that are part of protocol in the Outpatient Department. These guidelines will be used in a screening program by the service unit Health Educator in conjunction with the Hopi Tribe to provide computerized health appraisals for all adults.

At the Sacaton Service Unit, all primary care providers attended a seminar on "prescribing exercise." Each provider may now prescribe an exercise program for patients or make referrals to the Exercise Specialist.

Fluoridation

The Phoenix Area Fluoridation Coordinator is working with each service unit to obtain a data base on fluoride levels of community water supplies and to increase the level of awareness regarding the benefits of fluoride to dental health. Eleven community water systems have been fluoridated since the inception of this H.E.C. effort.

By the year 1989, the goal is to have tested every water system and to have each one properly fluoridated.

Nutrition/Obesity

The major emphasis in this Area is being placed on reducing the incidence of obesity which is an independent risk factor for hypertension, diabetes, and cardiovascular disease. The approach being taken is to obtain and maintain desirable weight by decreasing fat intake, increasing fiber intake, decreasing salt and simple carbohydrate intake, along with promotion of a more active lifestyle.

Sexually Transmitted Disease (STD)

Education of the target populations and developing protocols for STD management by primary care personnel have been the principal focus of activity for this objection. Prevention of the spread of sexually transmitted disease is primarily through diagnosis and treatment of index cases and their sexual contacts.

Smoking

The goal of the Phoenix Area is to have each IHS hospital, health center and clinic smoke-free by 1990. Many of the service units have already developed a written policy prohibiting the use of tobacco except in certain identified areas. At the Phoenix Indian Medical Center (PIMC), cigarettes are not sold in the hospital and the locations in which smoking is permitted are limited.

"Nicorette" chewing gum has been placed on the pharmacy formulary and is available for prescription on a limited basis through Family Practice.

Attempts are also being made to reduce smoking in Indian children and youth aged 12 to 18 years by introducing smoking education programs into school health curriculum.

Dental Health

All service units have adapted dental disease prevention plans. The most outstanding example is the institution of a formalized dental sealant program for all school age children on the Whiteriver, Keams Canyon and San Carlos Reservations. The Surgeon General's promotion of this relatively new Public Health procedure has greatly increased its acceptance as a dental disease prevention tool.

Surveillance and Control of Infectious Diseases

All service units will have written and implemented control procedures for nosocomial infections by 1990. Work is being done to provide infection control in-service education for each department within the hospital. Infection Control Committees have been established and are responsible for closely monitoring nosocomial infections. The Area Office requires reporting of nosocomial infections, as for two years this has been part of the Area's performance standards.

Recommendations

New approaches are needed to encourage the healthy to avoid behavior patterns that lead to disease, and to identify and treat the social and environmental causes of disease that originate in the community. The Phoenix Area recognizes the need to adapt our health systems to give greater emphasis to health promotion and preventive measures at individual and community levels. We also recognize that responsibility for health should not be exclusively the prerogative of the health professions. Protective and preventive measures should be a shared responsibility with the individual.

The Phoenix Area has conducted two annual training and motivational H.E.C. conferences. At each of these conferences, members of the service units and tribes have received specific instruction in two or more of the 15 emphasis areas. Tribal employees who participate are generally members of the health committees, of the tribal council and/or Community Health Representatives.

Although the Phoenix Area's Health Prevention/Health Promotion Plan is actively underway, it is understood that it will take a while to bring about a desired change of behavior. Therefore, it is important that special emphasis and reinforcement continue with the Health Emphasis Campaign on an annual basis so as not to lose the momentum generated thus far. These campaigns will incorporate the following:

1. A focus on an annual Health Prevention/Health Promotion Conference to bring IHS staff and tribal members together for the purpose of educating and sharing ideas on how to approach common health problems.

2. Special attention is needed now if we are to experience any change within the next five years in the alcohol and substance abuse problem throughout the Phoenix Area.

3. Between now and the year 1990, the Phoenix Area has set as its goal, meeting the objectives listed in the Fall of 1980, the Department of Health and Human Services document called Promoting Health/Preventing Disease: Objectives for the Nation.

In the category of disease prevention, there are probably only two truly "preventable" activities. If prevention is defined as "creating a situation where an entity (disease, injury or unhealthy state) cannot possibly happen," then the preventable activities are immunizations and fluoridation. THE REST OF THE INITIATIVES ENTAIL SOME TYPE OF EDUCATION, - usually to induce behavior modification either individually or institutionally. In the Indian Health Service, the first line of health promotion/disease prevention is the staff working predominantly in the field and taking healthy attitudes and practices into the communities and homes. In the Phoenix Area, this is being done more and more by the Community Health Representatives (CHR's). All of our CHR contracts are being changed to significantly emphasize the impact these members of the community can have as key players on the WELLNESS TEAM. They are being trained in home safety and encouraged to identify health and injury hazards around the home at every visit. They have been molded into a very effective team in the identification and follow-up of infants with acute otitis media. With very preliminary figures available, it appears as though this specific "otitis media" program will help significantly to reduce permanent hearing loss in Indian children located in all of our service units and tribal communities.

Since 1983, the Phoenix Area has spent approximately $250,000 in specifically identified wellness projects. This does not include the time donated nor the salaries of those people working primarily in the health promotion field. An increase in available resources would enable more training and when additional funds are identified, they will be targeted primarily in three broad fields, (a) preventing substance abuse, (b) improving nutrition and (c) promoting fitness levels of the beneficiaries of the Phoenix Area of the Indian Health Service.

Navajo Area Indian Health Service

Health Promotion and Disease Prevention

One of the major objectives of the Director of IHS in FY 1985 is to promote and implement disease prevention/health promotion programs. Our experience with the infant and child immunization initiative of the Service over the past several years has been most gratifying. Should this type of Health Promotion/Disease Prevention coordinated activity be expanded into other areas, we feel certain that successes of a similar nature can be achieved in those areas emphasized.

Indian patterns of morbidity and mortality have shifted quite dramatically since the founding of the IHS. For example, in 1960 the leading causes of death on Navajo were: (1) Accidents (16% of total deaths), (2) Influenza (12%), (3) Certain Diseases of Early Infancy (12%), (4) Gastritis, Enteritis, etc (7%), and (5) Diseases of the Heart (6%). In 1960, 40 percent of all deaths were to infants under the age of one.

By 1980 the leading causes of death on Navajo had shifted away from infectious diseases. The leading causes of death were: (1) Motor Vehicle Accidents (19.4%), (2) Other accidents (11.7%), (3) Heart Disease (9.8%), (4) Cancer (6.9%), and (5) Ill-defined (8.2%). Now only 8 percent of deaths are to infants under the age of one year.

The Navajo Nation still experiences a higher than expected morbidity and mortality due to infectious and communicable diseases. However, the emerging health problems of the 1980's and beyond are those that are related to chronic illness and a larger group of conditions related to lifestyle and behavior of individuals. It is significant to note that these emerging health problems can, for the most part, be prevented.

Morbidity and mortality events of the present and the future on Navajo, which must receive focused planning and intervention, include:

1. Under 4 years - Haemophilus infections: We hope to begin conjugated vaccine trials for serological response and efficacy in 7/85. Some work in this area is underway in the Alaska Area IHS as well.

2. Under 4 years - Gastroenteritis: Sanitation efforts are on-going and Rotavirus vaccine trials as sanctioned by the NIH may be carried out on Navajo, hopefully in the next year.

3. Under 4 years - Pneumonia: Improved nuturition and enhanced sanitation practices are necessary. Vaccination may be available nationally in a few years.

4. 1-20 years - Dental Caries: Improved hygiene and enhanced fluoride treatment programs are necessary. Peridontal disease programs need emphasis for young to middle age adults.

5. 15-55 years - Motor Vehicle Accidents: In the age group below 5 years we have cooperated with the Navajo Area-wide infant seat campaign. In the older age group, seat belt use and the reduction of alcohol abuse would contribute to improved health. We are encouraging continued emphasis on preventive education by the Emergency Medical Services Program staff serving the Reservation.

6. 10-65 years - Alcoholism: Intensified education programs at an early age are essential to success in reducing sequelae from alcohol abuse.

7. Up to 65 years - Obesity: Nutrition education, and exercise program development are needed to reduce diabetic, hypertensive, and other cardiovascular complications of the obese. Work with school boards and physical education program staff will be important to success.

8. 25-65 year - Diabetes: Education programs and special clinics have been an area of emphasis on Navajo in FY 85. Almost 1 out of every 30 visits to our clinics is by a diabetic patient. We have developed a 5-year plan to better identify diabetics and hopefully our education efforts will reduce the number of diabetics with complications in future years.

9. 25-65 years - Hypertension: Aggressive screening and treatment campaigns must be instituted.

10. Over 55 years - Pneumonia: In FY 1986 we will begin an aggressive campaign of immunization.

11. Over 55 years - Influenza: In 1986 we will intensify our vaccination program for this age group as well as for individuals at high risk. This emphasis area will have to continue on an annual basis.

The Service has demonstrated the ability to change to meet the challenges and improve the health care status of Indian people over the past three decades.

The emergence on Navajo of the Tribal Division of Health ten years ago has led to a valuable partnership between NAIHS and Tribal Health program staff. The Navajo Tribal staff most notably provide services through the CHR, EMS, Environmental Health, Home Health, Behavioral Health, Social Hygiene and Nutrition Programs.

We recently conducted a review of the collective Navajo Indian health status against the fifteen priority areas identified by the Surgeon General in 1979 and against the 200 plus Objectives for the Nation published in a DHHS Document in the Fall of 1980 entitled "Promoting Health/Preventing Disease". We rapidly discovered that the Navajo Area IHS data systems presently in place did not allow us to profile current status nor will these same systems allow us to track progress toward meeting the established National objectives. We also discovered many objectives for which no professional knowledge is presently available to enter into a data system which might be available in the future. Both of these needs will be addressed as we monitor our efforts, revise our plans and evaluate our program success in achieving Navajo-specific priority goals and objectives.

Senator **Bingaman**. Did you want other members of the panel to speak at this point, or are they here to answer questions?

Mr. **Ivey**. My understanding of the request, that we would be available here collectively for your questions.

Senator **Bingaman**. OK, thank you very much. Go ahead, Senator DeConcini.

Senator **DeConcini**. You want to start?

Senator **Bingaman**. No, you go ahead and ask whatever you have.

Senator **DeConcini**. I have several questions of this distinguished panel. I want to thank you, Mr. Ivey, for being here, too. Much of the testimony which the committee has received today is quite overwhelming to me, indicating that diabetes is—and maybe has for a long time, been in epidemic proportions among native Americans. Do you have the information here, you know, why is that the case?

We heard obesity and we heard nutrition, but is there some—why is this disease showing up among Indian people more than seems to be anything else, or is it just one of a number and it happens to be a little higher percentage?

I'd appreciate anything you can give to answer some of that. I knew it was high, but I didn't realize it was one in four, we heard today, among the pueblos.

Dr. **Gohdes**. As you know, Senator DeConcini, in Arizona the landmark research on type 2 diabetes is being carried on in the Indian community among the Pima Indians.

And what we understand from this research as well as other research carried on around the world, is that there may be something they call a thrifty genotype. That people who have lived——

Senator **DeConcini**. Pardon me, a thrifty——

Dr. **Gohdes**. A thrifty genotype.

Senator **DeConcini**. OK.

Dr. **Gohdes**. People who have lived under conditions of alternating feast and famine, or conditions where there was food at one time and not so much food at another, have evolved a certain type of metabolism that predisposes them, when lifestyles change, that is, ample food intake and decreased activity, to gain weight and to develop noninsulin dependent diabetes.

Now, this is a hypothesis you can't test in a laboratory, but Doctor Neel from the University of Michigan suggested this about 20 years ago as an explanation for the emergence of this form of diabetes in many groups of people around the world.

This is not a unique problem to American Indians, it is also occurring in Micronesia and other places in the world.

It appears that there is probably a thrifty gene or a particular diabetes-prone genotype, the exact mechanism of which we don't yet understand. Given this genetic background, as lifestyles have changed and people have become heavier, then diabetes emerges.

Senator **DeConcini**. Is that inherited, too?

Dr. **Gohdes**. The genotype is inherited. Within Indian families, there is a predisposition to develop noninsulin dependent diabetes if people gain weight.

Senator **DeConcini**. All right.

Dr. GOHDES. If one looks at the studies on Gila River, it's very clear that with one parent or both parents having diabetes, the risk goes up as the person's weight goes up.

Senator DECONCINI. Well, thank you, that's helpful. I had no idea, so even with long-term nutrition care, it would take a long sustained period of time to overcome it, because it's hereditary, it passes on to generation after generation, right?

Dr. GOHDES. Yes, sir. Doctor Kelly West in Oklahoma did a number of studies looking at the problem there. His conclusion was that prior to World War II diabetes was not a problem in the Indian communities in Oklahoma. After World War II as lifestyles changed and people's food changed and their activities changed, people became heavier and diabetes emerged as a clinical problem.

Senator DECONCINI. Thank you, that's very helpful. What percentage, Doctor Ivey, of the Indian Health Service Program activities are devoted to preventive health care?

Mr. IVEY. In terms of resource?

Senator DECONCINI. Yes, sir; do you know?

Mr. IVEY. Offhand, I would hesitate to give you a response. We could provide that for the record.

Senator DECONCINI. Could you provide that——

Mr. IVEY. Yes, sir.

Senator DECONCINI [continuing]. And could you provide it for the record in the areas, you know, like the Phoenix area, the Navajo area, Albuquerque area, or you know, half a dozen different areas?

Mr. IVEY. Yes, we can, we will do that.

Senator DECONCINI. I'd appreciate your doing that.

[At the request of Senator DeConcini for additional information, the following supplemental information was submitted by Mr. Ivey:]

RESPONSE RECEIVED FROM MR. IVEY

In response to the percentage of Indian Health Service resources that are allocated to preventive health care, the total for fiscal year 1985 is 8.14 percent.

As to the percentage of Indian Health Service resources by area allocated to preventive health care, the following percentages are for fiscal year 1985:

Aberdeen	9.63
Albuquerque	7.72
Anchorage	8.63
Bemidji	9.10
Billings	8.52
California	6.16
Navajo	9.25
Oklahoma	8.15
Phoenix	8.36
Portland	8.78
Tucson	10.10
Nashville	6.67

Senator DECONCINI. What proportion of Indian health problems which are now emerging in the Indian community in your judgment or somebody here really are preventable today? Are they all preventable if we have enough resources?

Mr. IVEY. Would anyone like to answer that?

Senator DECONCINI. I realize that's certainly a panoramic question, but I wonder what the experts think here?

Ms. WACONDA. I won't be the expert, but——

Senator DECONCINI. Well, pretend.

Ms. **Waconda**. To answer that question, I don't know that anyone can say how many of them have been preventable. However, I think that one can say that at least an attempt to prevent or modify the complications of those particular conditions that we find now certainly is realistic.

For instance, with diabetes, we may not be able to prevent diabetes. However, we may be able to prevent the complications of diabetes.

You're talking about overweight. You may be able in some ways to prevent overweight. But each one of those things would really be a specific topic that you'd have to deal with.

However, I might add the prevention activities, especially in the Indian Health Service, have shifted considerably from dealing with the specific patient with a clinical disease, and shifting over to prevention earlier in the person's life.

In the Albuquerque area, we have demonstrated several different projects with working with the BIA schools and the State schools, in which we are really starting with education of the children regarding lifestyle habits, which does include accident prevention, nutrition, stress, even at that age, stress management, and those kinds of things, from the kindergarten level all the way through the 12th grade.

Now, it's true that not every school has that, but an attempt is made to begin that, and to work directly with the Department of Education, with the BIA, to hopefully get that going.

Senator **DeConcini**. The same would be true on alcohol abuse and——

Ms. **Waconda**. That's right.

Senator **DeConcini** [continuing]. Chemical abuse?

Ms. **Waconda**. That's true.

Senator **DeConcini**. If we had programs or assets and resources, you think it would be—well, let me put it this way: There's no knowledge here that—that thinks that the cultural society of any of the native Americans would not be receptive to a good education preventive program say in alcoholism?

Ms. **Waconda**. Probably not, but yet at the same time, there are differences among the different groups of Indian people, so that I think it makes it very important——

Senator **DeConcini**. Can't compare them all?

Ms. **Waconda**. That's right, that you can't say that one particular kind of education would be acceptable in all communities, and I think that's what stresses the necessity for those of us who are in the health provider field, that we really know the community well, and that we work directly with the tribal groups to really find out what is acceptable in that particular community.

As you heard this morning, the one thing that went just great was the one at Zuni.

Senator **DeConcini**. Yeah.

Ms. **Waconda**. For some reason, and probably they're numerous, something happened and it really did work. The same thing might happen in another community, whereas in another Indian community, maybe running just wouldn't be the thing.

Senator **DeConcini**. One more question, Mr. Chairman. Let me just ask you, Doctor Ivey: Can the Indian Health Service's present data system provide a profile of current Indian health status to determine how IHS is doing in terms of meeting the national health objectives set by the Surgeon General?

Mr. **Ivey**. I think that I would have to say that our data system at present isn't organized in such a way that we could provide a specific answer to that question in terms of the disease entities that you ask about. But since it is an emphasis of the Indian Health Service, and of course the Department, we are working toward that effort, and I would hope that we would be in a position to be able to have that information here within the next year or so.

Senator **DeConcini**. Do you have the technical capacity?

Mr. **Ivey**. We don't presently have the technical capacity throughout the system, but with the ADP plan that we're in the process of developing, the plan would provide us with that capability.

Senator **DeConcini**. Thank you. I have no further questions.

Senator **Bingaman**. OK.

Mr. **Ivey**. Mr. Chairman, Mr. Lincoln may have something to add to that.

Senator **Bingaman**. Sure, go right ahead.

Mr. **Lincoln**. Senator, there is a national effort within the Indian Health Service through our chief medical officers at each area, and through our office of program operations in Washington to collect the information that you've just asked for.

As an example, there are 15 priority areas identified by the Surgeon General. There are in excess of 200 objectives identified that come under those 15 priority areas. Each area has been directed by our Washington office to start collecting data and start describing program efforts related to those 15 priority areas and 200-plus objectives, and then obviously to identify what activities we propose to undertake in those areas over the next 3, 5, 10 years, and so that information is coming.

Senator **DeConcini**. Thank you. Thank you, Jeff.

Senator **Bingaman**. Yeah, let me just ask a couple of questions. I was just like Senator DeConcini, very startled with the statistics on diabetes, the idea that one out of four native Americans in this country can be expected to contract diabetes. That's an amazing statistic, to my mind, at any rate.

And I was impressed with the program that I gather the Indian Health Service has going at Zuni to deal with it.

What would be necessary to take that program and do it in an entire region or area office or however you would do it? I mean, why—if it's working at Zuni, if people are happy with it at Zuni, I understand that you might find it doesn't work everywhere else, but why not at least try?

Dr. **Gohdes**. We do have a diabetes program with five model projects sites now, where we are utilizing an approach to diabetes health services. We do have exercise classes in other areas of the Indian Health Service.

Senator **Bingaman**. You say you've got five places?

Dr. **Gohdes**. We have five demonstration projects for diabetics.

Senator **Bingaman**. And Zuni is just one of the five?

Dr. **Gohdes**. Zuni is not one of the diabetes demonstration projects.

Senator BINGAMAN. Oh, it's not.

Dr. GOHDES. This is an initiative that has been developed at Zuni.

Senator BINGAMAN. Oh, I see.

Dr. GOHDES. The problem of diabetes is very widespread, and some of the approaches we've taken in Zuni, we have also taken in the diabetes demonstration projects. You heard this morning about the school project in the State of Arizona, in cooperation with Indian Health Service and the diabetes project at the Sacaton Service Unit. Some of these approaches that we have been describing, we are in fact doing in other places.

Senator BINGAMAN. Well, why——

Dr. GOHDES. Replicating this is a difficult question. And one of the things that it requires to replicate something like this is the training for people so they understand how to do this and have the resources to develop.

We are developing training in diabetes. We've done a lot of it, we have more of a market for it, and we just keep on trying to take successful demonstration projects and disseminate them.

Senator BINGAMAN. At the rates you're disseminating these projects, how quickly would you expect to be able to do something like what they're doing at Zuni, Indian Health Service-wide?

Mr. IVEY. Well, I can at least start the answer. I would think that we're talking about several years here, at least. The projects that Dr. Gohdes spoke of are I believe somewhat broader than the one that was mentioned this morning at Zuni. I think your original question and my interpretation was that it asked about the Zuni project.

Senator BINGAMAN. That's the only one I've heard a description of.

Mr. IVEY. Right.

Senator BINGAMAN. But if you want to describe one of the other five——

Mr. IVEY. I think that might be useful.

Senator BINGAMAN. OK, what do you do in these other five?

Dr. GOHDES. What we've done is organized health care delivery services for the patients with diabetes into a preventive mode—rather than waiting for the patient to come in with an end-stage complication. We go out there to the patients, educate them, screening them for complications at a time when those complications can be treated. We identify the patient as a member of a family and community with a predisposition to diabetes.

There are three elements to the demonstration projects. First is the model clinic developing the preventive health services. Teaching other professionals to do this in other service units is the second element.

The third involves getting the information into the communities so people understand about diabetes: Why Indian people are prone to it, what they can do about it and how they need to take care of themselves.

We have developed a course like TB today, only we call it diabetes today, to train other health care professionals in these aspects of diabetes.

Senator BINGAMAN. OK; let's—go ahead. Someone else want to comment?

Mr. **Jensen**. A couple of different thoughts though. One of them is that not everywhere is it as widespread [illegible] as high an incident rate such as that of the Gila River or maybe other locations that you've been hearing about.

So I don't know that we would necessarily want an IHS-wide program where there may be other problems more important to a given tribal group.

I would like to think a little bit further as to whether I really would want to see a diabetes program at every one of our locations as a major emphasis. With limited resources, I think we want to go with the area that is of major concern. On the other hand, in the objectives for the Nation, diabetes has been added to the hypertension issue in terms of attempting to focus attention, because it is definitely a major problem.

Senator **Bingaman**. Let me ask you about—you testified that you had good cooperation with the BIA and trying to work, and you have some projects going forward to teach youth better health habits.

My information, and it's very sketchy, but my information is that there's not a great deal being done in the BIA schools or the elementary schools or otherwise, and most—in this State or elsewhere, to teach children about nutrition or avoiding alcohol problems or avoiding smoking or any of the other things that are generally recognized as health hazards.

Now, have I just been misled on that, is there a lot going on that I'm not informed of?

Ms. **Waconda**. I wouldn't say that every school does have those activities going. However, I think that nationally in the Indian Health Service there has been a change.

And the trend is now that we encourage our health workers to work more directly with the community programs, and whereas before that wasn't being done maybe quite as much.

And for instance, in the Albuquerque area, in three of our local schools in two given pueblos we are teaching, but that's still leaving a whole gap of other schools that serve Indian children in which nutrition isn't taught, so it's slow——

Senator **Bingaman**. So these are three elementary schools?

Ms. **Waconda**. Yes, it's slow and it's getting started and we are encouraging people, our health workers, to go individually into school systems and deal directly with the school principals and the community to try to get things going.

But you are right in saying that it is not certainly every school. However, at least a trend has been set.

Senator **Bingaman**. To get an idea of how prevalent it is, you're talking about three schools where nutrition is being taught out of how many in the Albuquerque area?

Ms. **Waconda**. Let's see, how many—we have I would say at least—now, this is really a rough figure in the Albuquerque area, but considering the 19 pueblos, at least a day school out in each one of the pueblos. That's 3 out of 19.

Senator **Bingaman**. So you think 3 out of 19 schools it is being taught?

Ms. **Waconda**. I do know for a fact that it is being taught.

Senator **Bingaman**. And that's at all grades?

Ms. **Waconda**. That's K through 6th.

Senator **Bingaman**. K through 6th.

Ms. **Waconda**. These are demonstration sites, and we're hoping that by meeting with the principals from the other schools, that they will, of course, buy into this system as well. But it's a—I agree, it's a very slow, lengthy process.

And as you were asking about time in the Albuquerque area, we have—just beginning to develop a 5-year plan, and we're hoping that meeting these 15 national objectives in health promotion and disease prevention, at least we will have some record within 5 years to demonstrate that we have done something, but that certainly isn't to say that we have done everything, or we will have done everything by that time.

Senator **Bingaman**. Let me just ask a final question, picking up on something that Mr. Miike said when he started today. He said that there was a perception, or at least I understood him to say, there was a perception among tribes, that the IHS did not involve them as a partner, it involved them more as a parent-child relationship and they didn't feel they were having the input that they would like to have into these issues. Is that a fair criticism, is it wrong, what's your perception?

Mr. **Ivey**. Well, I think that historically that maybe is more true in the past than it is now, but that's not to say that efforts can't be and shouldn't be made to improve that relationship.

Since the passage of 638 and with more contracting with the tribal groups, much more of these discussions have occurred in terms of the development of the health boards and the different organizations that our people work with. We are trying to overcome that particular notion that that does exist, and historically it may be more true than now. That's not to say that what he said doesn't have some merit.

We are aware of it, and in each of the areas we do encourage, and in fact insist, that the management of the Indian Health Service programs in the service units meet with the tribes for consultation. That's an effort that continuously needs improvement.

Senator **DeConcini**. May I ask another question?

Senator **Bingaman**. Go ahead, sure.

Senator **DeConcini**. I just thought of one thing. Are you familiar, Mr. Ivey, with what the Senate budget passed 2 weeks ago, what the figure was for Indian Health Service?

Mr. **Ivey**. No, I don't have access to that information.

Senator **DeConcini**. OK; I don't, either, I can't remember. We had so many different figures there. I was wondering how that—if the Indian Health Service had done any analysis of what that's going to do if that figure sticks.

Mr. **Ivey**. We haven't.

Senator **DeConcini**. OK.

Mr. **Ivey**. At least as far as I know.

Senator **DeConcini**. OK.

Mr. **Ivey**. We haven't received the information.

Senator **DeConcini**. Well, we'll get into that later. Thank you.

Senator **Bingaman**. Did you have a comment?

Mr. **Jensen**. Specifically to the health emphasis campaign in the Phoenix area, we have conducted now 2 years in a row an annual conference at which we have invited and had participation from all of the tribes within the area, and we plan another one this fall, picking off essentially each of the emphasis activities for each of the years.

And I think that we've already essentially heard that health promotion and prevention activities are highly educational in nature. And I think what we attempt to do through these conferences is create a heightened awareness upon which then to begin to build these other programs.

Senator **BINGAMAN**. Let me just ask a final question, and then I'll let you all go, but in this bill that we put together, this S. 400, we've got a—we call on the Indian Health Service to do a great deal in the way of planning, to implement programs, to work with tribes, to implement plans, to work on preventive health.

How much of a change and how much of a burden are we trying to impose on you folks? Is this thing unreasonable, given your present other responsibilities, is this something that you can do, is it something you are doing? You know, I'd be interested in your reaction.

Mr. **IVEY**. I don't think it is unreasonable. I think the Indian Health Service, as we testified, supports the goals and objectives of S. 400. I don't believe that it would require that much additional time in order to look at the record of what the Indian Health Service is doing in terms of services. As the disease patterns and conditions have changed, we have, of course, been changing and moving in that effort for the last 20-some years.

It would seem to be a natural outgrowth as we become more aware of diabetes and the community injury control measures and the need because the high rate of accidents. As we look at the epidemiology of where our cases are coming from, it would certainly seem to be indicated as far as a need for us to move.

Senator **BINGAMAN**. Ok, thank you very much, we appreciate your testimony.

Senator **DECONCINI**. Thank you very much.

Senator **BINGAMAN**. Who have we got next? The next is a panel on demonstration and model programs. Cheryl Watkins, who is the coordinator for the Chemical Awareness Program in Phoenix Union High School District in Phoenix, AZ; Sally Davis, who is the educator of the department of pediatrics at the University of New Mexico School of Medicine, and Ken Hunt, who is the project coordinator for the Community Adolescent Health Program in Albuquerque.

Thank you all for coming. We appreciate it, and why don't we go right ahead. Cheryl, do you want to start out and give us your testimony? Thank you for coming all the way to Gallup.

STATEMENT OF CHERYL WATKINS, COORDINATOR, CHEMICAL AWARENESS PROGRAM, PHOENIX UNION HIGH SCHOOL DISTRICT, PHOENIX, AZ

Ms. **WATKINS**. Thank you, it's my pleasure. Chairman DeConcini and Senator Bingaman, it's a real honor to be here. This bill is excellent and I'm pleased to be a part of it. I implemented and developed the Chemical Awareness Program in the Phoenix Union High

School District, which is the largest high school district in Arizona. It's eight comprehensive schools. And I train and coordinate schools statewide in developing chemical awareness programs in their school system, and in the past 4 years, I've worked in networking our State together to implement, push through a bill this year that supports schools statewide in developing chemical awareness programs throughout the State.

And what this bill does is provide some seed money for schools to begin and to expand, and it coordinates the statewide effort through the department of education to provide technical assistance to schools statewide.

I started those programs because I could not stand the pain and the problems that I saw in the classroom in which I was teaching. There was no help available for the kids within the school, teachers did not understand the problem, they did not know what to do about it, and the kids simply were not getting the help.

I spent my first 5 years studying programs around the country that were working, and I implemented a pilot program at my own school.

This happened 3 years ago. Our district supported it. They were very pleased with it. This year we're in five of the comprehensive high schools. Next year we will complete the program expansion with all eight.

These programs are working. My school district has totally bought in to this, the school board, the administration, the superintendent, principals down.

Because of this, in the past 3 years we have inserviced and retrained 663 staff members, referred over 2,500 kids to help that have never been identified and referred before.

We have group counselings, support groups for kids on campus. We're seeing some real miracles take place in these groups. We ask the kids, what are you getting out of these groups? Sixty-one percent are saying, I am cutting down on my use and I'm stopping.

Seventy-four percent said, I'm finding new positive ways to deal with my problems. Sixty-two percent said, I'm finding new positive ways to deal with stress. Sixty-seven percent, my feelings of self-worth and self-esteem are going up.

We find that teachers are getting well. We're intervening on our own staff members. Teachers are getting their kids and their own families to help. They are now able to be more effective in the classroom as they teach.

Instead of suspending kids, we refer them to help so they can start dealing with the problem that is creating this harmful behavior. I don't believe in punishing an illness and a disease. We are getting them to help. We have groups that are alternative to suspension where we can begin to intervene and help them see relation between their alcohol use and their problems.

At the last three schools where we implemented the program, 300 students volunteered for help. These programs are wanted by the kids, they're hurting. The faculty want it. The parents, they're all crying for help and we now have something that is working.

The problem is very great. It touches all our lives. It's maiming our families and our kids, and this no longer needs to happen because we now have the knowledge, skills, and programs to combat this serious illness. And the key, if we're really going to deal with this problem, is in the schools.

This is where we can reach the masses. And implementing it in the schools, it's going to be cheaper. On my high school campus with 2,700 kids, I can put in a comprehensive program for $7,000.

It costs $27,000 to house one student in a correctional facility, at Abode Mountain for 1 year.

These programs must be comprehensive, kindergarten through 12, and they must be culturally adapted to the needs, so that everyone is reached equally.

What is happening is the entire educational system is buying into this, and my—we're impacting 17,000 students and over 1,000 teachers.

Through the State legislation, schools statewide are feeling supported, and out of this, I talked to the dean of education at Arizona State University, and he said, because of this, we're going to have to change our teacher training and we're going to have to start training all our teachers to learn how to deal with this.

And I see this complete system change happening in our school district and community, and I see this can happen also on the reservations dealing with the Indian population as well.

As part of an action plan, I have developed a pilot project where this model could be implemented. The model is for two consultants, whom I feel are doing the finest work in the country in dealing with early prevention programs, kindergarten through 6, and intervention programs 7 through 12.

Pilot sites will be identified. In my own school system, we have a sizeable Indian population in eight high schools, to pilot a culturally sensitive program in the public schools.

At Phoenix Indian High School, I would also like to see a pilot program. It's a boarding school that's within the city limits. To complete the pilot project, I would like to see a kindergarten through 6 prevention program on the reservation.

I'd like to see a planning committee come together with the two consultants, and with the Indian Alcoholism Program, it is there, with the local tribes that the program can sensitize to the culture.

I think this program should be piloted for 1 year, and that specific training be developed so that core teams can come in and receive training and go out and impact their community.

Chemical abuse and dependency is mutilating the minds, bodies, and spirits of our youth, and it doesn't have to happen, today we have the knowledge, the skills, and the programs that are working.

Senator **Bingaman**. Thank you very much, appreciate that.

[Ms. Watkins submitted a prepared statement, "Programs That Are Working: Chemical Abuse Programs in the Schools," and a related pamphlet for inclusion in the record:]

Chemical Awareness Training Institute
Cheryl Watkins, Director • 21 E. Muriel • Phoenix, Arizona 85022 • (602) 863-9671

PROGRAMS THAT ARE WORKING

Chemical Abuse Programs in the Schools

Three years ago a comprehensive Chemical Awareness Program was piloted in the largest high school district in Phoenix, the Phoenix Union High School District (P.U.H.S.D.) with Maryvale High School serving as the exemplary school. Today, the program has expanded to five campuses. Over 663 staff members have received 8-12 hours of education on chemical abuse, intervention and referral; 102 volunteer staff have received 32 hours of additional training and over 2,500 students have been referred to help. The P.U.H.S.D. has taken great pride in the success of the program and has allocated funds to extend the program to its three remaining campuses for the 85-86 school year.

The P.U.H.S.D. Chemical Awareness Program is a comprehensive program which includes prevention, intervention, identification , referral and support. An important contribution to the success of the program has been the support groups. These groups provide support within the school for students who are in need of help. One-hundred and thirty students surveyed in the school support groups indicated:

1) 61% decrease or elimination of all chemical use.

2) Over 78% felt the groups had a positive affect upon their ability to communicate and express their feelings in a positive way to others.

3) 67% felt the groups had a positive affect on feelings of self-worth.

4) 74% felt the groups had a positive affect on their ability to find new positive ways to deal with their problems.

5. 62% found new positive ways to cope with stressful situations.

Four types of groups are offered to meet the individual needs of students; these include 1) students affected by alcoholism in the home,) sobriety support groups, 3) intervention groups and 4) prevention mental health groups for high risk students not yet involved with chemicals.

Chemical Awareness Training Institute
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Other components of the program are parent and community education; curriculum development; articulation with treatment agencies, law inforcement, business and government agencies.

Chemical abuse programs are working. This is indicated by the fact that 1) students and families are being identified and referred to help, 2) students are learning to say no and 3) students are intervening with their peers. In addition, with early intervention, the chances of recovery are greater and the cost in terms of dollars and human potential become less and less. In Phoenix, it cost $27,000 to house one juvenile one year in a correctional facility as compared to $7,000 to maintain a comprehensive program in one large high school of 2,700 students.

Chemical abuse and dependency continues to be the most serious health problem facing our nation today. This problem knows no distinction among age, sex or culture. Statistics indicate that, nationally, 1 out of 3 families in the United States are being damaged by alcohol and 80% of Arizona prison inmates are serving time for alcohol and drug-related offenses. Local high school statistics in Phoenix indicate that students are using more and more and starting younger. A recent high school survey in Phoenix indicated:

1) 73% of students surveyed had observed violence because of chemical use.
2) 70% started using chemicals in the 7th and 8th grade.
3) 32% have attended school under the influence of marijuana at least once.
4) 80% of the 11th and 12th graders indicated riding in a car with a driver under the influence of a mood-altering chemical.

The greatest potential for reaching students and their families is through the schools. Comprehensive programs should be in all schools grades K-12. Each school, then, adapts its program to the cultural needs of students so all are equally reached. In order for this to happen within the Indian school population, I would suggest the following action plan:

1) Identify two people who will coordinate the project and who have expertise in Chemical Awareness School Programs. I would like to suggest:

--Rokelle Lerner, co-director of Children are People, 493 Selby Avenue, Saint Paul, Minnesota 55102 (612) 227-0431. Ms. Lerner has developed the finest programs and training in the country for children in grades K-6. Her programs are now being used in over 212 schools and her curriculum has been adapted to special needs of the Indian population.

--Cheryl Watkins, Phoenix Union High School District Chemical Awareness Program Coordinator, state-wide consultant for programs and director of the Chemical Awareness Training Institute, 21E. Muriel (602) 863-9671. She has developed programs state-wide for grades 7-12 and will be developing a special component to her current Chemical Awareness Program to serve the Indian population in eight P.U.H.S.D. schools.

2) Rokelle Lerner and Cheryl Watkins will develop and coordinate a comprehensive K-12 model program to be implemented at the following three pilot sites, if agreeable with administrative staff:

--Phoenix Union High School District Indian population on its eight campuses.

--Phoenix Indian School. A boarding school which serves Indians off the reservation grades 9-12.

--An elementary school on the reservation in close proximity to the Phoenix area.

3) A steering committee will be identified to develop, implement and support the pilot program. Federal, state and local decision-makers will be invited as well as school, agency and community personnel.

4) The pilot program will be implemented and evaluated for one year. The program shall include the following:

--Survey of students needs

--Total staff inservice

--Chemical Awareness Team selection and training

--Student support groups on campus during school

--Parent and community education and support

--Development of referral systems within the school and to outside agencies

--Development of ongoing staff training

--Policy development

--Curriculum development

5) Through the nonprofit organization of Children are People Inc. and the Chemical Awareness Training Institute, core teams from other schools will be trained to implement programs in their own schools.

We must act now, chemical abuse is mutilating the bodies, minds and spirits of our youth. It does not have to happen. Today we have the knowledge, skills and power to stop this devastating disease.

Phoenix Union High School District

Chemical Awareness Program

A comprehensive prevention/intervention program for students and their families affected by the abuse of alcohol and other drugs.

Superintendent
Dr. Timothy J. Dyer

District Program Coordinator
Cheryl Watkins

A Problem That Affects Everyone

Local and state statistics indicate:

- 34% of the families in Arizona are being damaged by alcohol abuse.
- 40% of the students at a local high school have come to school under the influence of alcohol or marijuana at least once.
- 14% of the students indicated that they drink two or three times a week or more.
- 73% say they have observed alcohol- and/or drug-related violence.
- 80% of all Arizona inmates are incarcerated for drug-related offenses.
- United States industry suffers an annual $65 billion loss because of alcohol abuse.

[illegible]

Chemical dependency is a treatable health problem that is increasingly affecting our students and their families. Students can't make full use of the total school program if they are harmfully involved with chemicals which seriously inhibit their ability to learn.

Schools must begin to share in this responsibility for helping students with chemical dependency problems that threaten the learning and overall development of each student. The complexity of the problem requires a cooperative effort from the school community and the family. It is therefore necessary that school districts provide their students and teachers with a comprehensive chemical awareness program.

Goals

To raise the level of awareness of staff, parents and students.

To intervene early with student and families harmfully involved with chemicals.

Provide a support and referral system on and off campus.

Improve student attendance, academic performance and reduce dropouts.

Program Description

Faculty Inservice

The entire staff receives eight to 12 hours of training on chemical dependency in areas such as identification, intervention and referral.

Chemical awareness team selection and training

Twelve to 20 staff volunteers receive 32 hours of specialized training in assessment, evaluation and group facilitator training.

Student support groups

Groups meet once a week during the school day. These groups are led by a trained staff member and a community professional.

There are four types of groups:

Insight

For students harmfully involved with alcohol and other drugs. Students are referred through policy as an alternative to suspension, others are referred by staff, parents or students.

Concerned persons

For students whose lives are being affected by the chemical abuse of loved ones.

Staying straight

For students who choose to live a chemical-free lifestyle.

Sharing

For students wishing support for problems not related to alcohol or drug abuse.

Parent education and support

Parents are provided education and offered support systems for change.

Other program components

- — Prevention groups
- — Inter-disciplinary chemical awareness curriculum guide.
- — Development of board policies and procedures
- — Surveys and program evaluations
- — Articulation with community agencies, law enforcement, elementary feeder schools, business and government.

Program Evaluation

- — Since the program's inception 2½ years ago in 1982, more than 2,000 students have been referred into the program.
- — Students attending support groups in three schools indicated a 61% elimination or decrease of alcohol and other drug use.
- — Nearly 26% continued to use, but felt a greater awareness of the problem.
- — Over 78% felt the groups had a positive affect upon their ability to communicate and express their feelings in a positive way to others.
- — 67% felt the groups had a positive affect on their feelings of self-worth.
- — 74% felt the groups had a positive affect on their ability to find new positive ways to deal with problems.

"Alcohol is killing our teenagers, it is killing them on our highways and crippling their potential for success. This Chemical Awareness Program is helping to prevent this tragic loss."

— Senator Jacque Steiner, R-Phx.

"I learned to face my problems instead of running away from them."

— Student participant

"These programs are the first ray of hope we've seen."

— Arizona Supreme Court
Justice Frank Gordon

"I learned that a lot of people have the same problems as I do, I'm not alone."

— Student participant

"We'd like to tell every school district in the country about our program — it's that good, that rewarding and that fulfilling."

— Don Kennedy, President,
PUHSD Governing Board

"I can handle problems and situations better. Helps to know that someone will listen."

— Student participant

PHOENIX UNION HIGH SCHOOL DISTRICT NO. 210
QUI DOCET DISCET
1895

GOVERNING BOARD

Don Kennedy

Scot Butler

Judith Pettit

Mary Price

Mary Carr

Senator BINGAMAN. Sally, go right ahead.

STATEMENT OF SALLY DAVIS, EDUCATOR, DEPARTMENT OF PEDIATRICS, UNIVERSITY OF NEW MEXICO SCHOOL OF MEDICINE, AND PROJECT DIRECTOR, COMMUNITY ADOLESCENT HEALTH PROGRAM, ALBUQUERQUE, NM

Ms. DAVIS. OK, I'm here in two capacities today. First, as an educator for the department of pediatrics at the University of New Mexico, and as a project director for a number of projects in Indian communities.

Ken Hunt, my colleague, is going to describe in a little more detail the Teen Center projects that we have.

We also have a cardiovascular intervention curriculum in eleven schools in the Checkerboard area which is aimed at prevention of cardiovascular disease. These are primarily Indian populations.

We also have an absentee alcohol prevention project at Laguna-Acoma that Ken will briefly describe, to look at using absenteeism as a way to identify students early for intervention programs.

I'm here in a second capacity, to briefly read part of William Wiese's testimony. Bill—Doctor Wiese—is the, is a professor in the department of community, family and emergency medicine. He has been involved for at least 15 years in programs through the university serving different tribes in New Mexico with specific demonstration projects for training and health education.

And he is the head of the division of community medicine which has as its specific goals prevention and promotion.

Since you have the entire testimony in writing, I would just briefly bring up some of the points that were suggestions of Doctor Wiese:

> For a preventive approach to be more fully assumed by the IHS, a special mandate needs to be authorized and backed by planned and funded programs. Preventive programs are intuitively attractive as a means of breaking the links between risk factors and illness and injury and as a means of reducing the cost of health care.
>
> However, such proposals need to be carefully planned and evaluated. Their feasibility, acceptability, and effectiveness are not always assured. Their cost-effectiveness, even if the incidences or illness or injury are successfully reduced are not automatic.
>
> The committee should view S. 400 as having its principal objective to improve the health and well-being of Indians at section 2.1-A.
>
> The committee must be justifiably hopeful, but should also be cautious in its attempts to reduce the medical expenses of Indians. Section 2.1-B.
>
> The benefits of disease prevention and health promotion in the future in terms of the anticipated reductions of premature morbidity and mortality.
>
> Substantial implementation costs for serious programs need to be anticipated. One has to be realistic about the limits of our knowledge concerning the impact we can expect on influencing human behavior and on the linkages between behavior and illness outcome.
>
> The influence of overlying social and economic factors that are largely beyond the direct impact of planned programs need to be considered as well.
>
> It is inappropriate to anticipate that effective health promotion effects will be simple, necessarily effective or cheap.
>
> In summary, the health burdens of Indians are great, and the need for special development of vigorous approaches for disease prevention and health promotion are clear.
>
> The task will not be simple. It will vary among tribes as the needs differ. Nevertheless, the ideas and the objectives of S-400 have my strongest support.

Senator BINGAMAN. Thank you very much.

[Ms. Davis submitted the following material for inclusion in the record: A prepared statement of Dr. William H. Wiese of the University of New Mexico School of Medicine; a program description of the National Indian Fetal Alcohol Syndrome Prevention Project; a paper from Alcohol Health & Research World, "A Pilot Project Fetal Alcohol Syndrome Among American Indians"; and a paper "Epidemiology of Fetal Alcohol Syndrome Among American Indians of the Southwest." Testimony resumes on p. 230.]

THE UNIVERSITY OF NEW MEXICO
SCHOOL OF MEDICINE
ALBUQUERQUE NEW MEXICO 87131

May 24, 1985

Written testimony of William H. Wiese, M.D., submitted to the Senate Select Committee on Indian Affairs with regard to S. 400, the Indian Health Promotion and Disease Prevention Act of 1985, in conjunction with the field hearing at Gallup, New Mexico on June 1, 1985.

To the Senate Select Committee on Indian Affairs:

I feel I am qualified to comment on S. 400, the Indian Health Promotion and Disease Prevention Act of 1985. I am a physician on the full-time faculty of the University of New Mexico School of Medicine in Albuquerque for the past 14 years. I am professor in the Department of Family, Community, and Emergency Medicine and Director of the Division of Community Medicine. Prevention and health promotion are among the priority subject areas of the Division. For nine years (1972-81), I was project director for the University of New Mexico-Navajo Area Health Education Center which was a multi-faceted program to develop and implement the entry and support of Indian manpower into the health professions at all levels. For many years, I was the director at the University of New Mexico for the Indian Health Service's Community Health Medic Training Program in Gallup. I have been involved with a wide variety of other projects and programs involving Indian health in New Mexico. I spent one year (1979-80) studying and working with the Stanford Heart Disease Prevention Program's community intervention project. I am active nationally as a former director of the Association of Teachers of Preventive Medicine. I am presently a member of the U.S. Preventive Services Task Force.

My comments are my own, and not necessarily representing others at the University of New Mexico. I am not aware of views of others at UNM which differ from mine, however. I would like to address S. 400 generally and then specifically with regard to Section 204.

The Indian peoples of the United States carry special health burdens in terms of incidence and prevalence of disease and injury. These vary somewhat among the tribes across the country. Some have been extensively studied and others require further study. It is apparent that many of the conditions involve antecedents and risk factors that are subject to intervention. Among the most obvious of these are the diseases, injuries, and deaths connected with alcohol use. Tobacco use and its sequelae vary greatly across different Indian tribes. Indian groups vary in prevalence of such conditions as diabetes and hypertension. For many, these conditions have extraordinary prevalence rates. Certain cancers are prevalent among Indians. Indians are exposed to a variety of occupational risks that have gone unattended.

DEPARTMENT OF FAMILY, COMMUNITY, AND EMERGENCY MEDICINE
DIVISION OF COMMUNITY MEDICINE 2400 TUCKER AVE. NE TELEPHONE 505: 277-3253

It should be noted also that many of the conditions are changing in their incidence and importance over time, presumably reflecting shifting sociologic and cultural patterns and living conditions. In previous years, tuberculosis, other infectious diseases, and concerns about maternal and child health were central. With a number of social changes and health interventions, especially through the Indian Health Service, these conditions have largely been controlled. On the other hand, alcohol and motor vehicle crashes have been a continuing problem. We have reason for concern that the chronic conditions that have plagued many other American populations, such as cardiovascular disease, are now on the rise in Native American people.

The Indian Health Service has for many years advocated preventive and public health approaches to be included in its overall programs. There has been a record of success in such areas as immunization and maternal and child health. It must be acknowledged, however, that the IHS has been limited in the extent to which it has been able to pursue a preventive approach in view of the unremittant burden and demand for services to manage acute and chronic illness and injury.

For a preventive approach to be more fully assumed by the IHS, a special mandate needs to be authorized and backed by planned and funded programs.

Preventive programs are intuitively attractive as a means of breaking the links between risk factors and illness and injury and as a means of reducing the costs of health care. However, such proposals need to be carefully planned and evaluated. Their feasibility, acceptability, and effectiveness are not always assured. Their cost-effectiveness, even if incidences of illness or injury are successfully reduced,are not automatic.

The Committee should view S. 400 as having its principal objective to "improve the health and well being of Indians" (Section 2(1)(A)). The Committee may be justifiably hopeful but should also be cautious in its attempt to "reduce the medical expenses of Indians" (Section 2(1)(B)).

The benefits of disease prevention and health promotion are in the future, in terms of the anticipated reductions of premature morbidity and mortality. Substantial implementation costs for serious programs need to be anticipated. One has to be realistic about the limits of our knowledge concerning the impacts we can expect on influencing human behavior and on the linkages between behavior and illness outcome. The influence of overlying social and economic factors that are largely beyond the direct impact of planned programs need to be considered as well. It is inappropriate to anticipate that effective health promotion efforts will be simple, necessarily effective, or cheap.

In summary, the health burdens of Indians are great and the need for special development of vigorous approaches for disease prevention and health promotion are clear. The task will not be simple. It will vary among tribes as the needs differ. Nevertheless, the idea and objectives of S. 400 have my strongest support.

~~I have~~ several specific comments regarding Section 204, Health Promotion and Disease Prevention Demonstration Project.

As described and if implemented, the activities in this section constitute more of a specific planning analysis than an actual demonstration project. The limited time frame (18 months) and the scope specified activities would preclude the actual setting up and running of any substantial project. I offer this comment as a point of clarification rather than criticism. The proposed activities are indeed appropriate. In its planning process, to be carried out under section 203(b), the IHS would presumably include a set of developmental or demonstration phases to carefully document and evaluate the impacts of its preventive activities.

I feel that several demonstration projects as described in section 204 would be preferable to just one, because of wide tribal differences and conditions across the country.

The University of New Mexico has the capability to work with the IHS in implementing a demonstration project, and would give serious consideration to applying for a grant or contract to do so.

The Senate Select Committee should review the relationship between the planning activity required of the Service in section 203 and the demonstration activities in section 204. The former should benefit from the latter. The demonstration project(s) would run for 18 months, starting six months after enactment. (This is a minimal time frame.) The Service report to Congress is required at 12 months after enactment. It would be reasonable to allow for a phasing in of the Service planning effort over a longer time period so that results of the demonstration project can be taken into account.

This ends my comments. Overall, S. 400 has my strong support.

William H. Wiese

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PROGRAM DESCRIPTION

NATIONAL INDIAN FETAL ALCOHOL SYNDROME PREVENTION PROJECT

The Fetal Alcohol Syndrome Prevention Program is funded by the Indian Health Service (IHS) through the All Indian Pueblo Council (AIPC). It began operation in Fall of 1983. The current funding will insure operation through 1984.

Fetal Alcohol Syndrome (FAS) is an irreversible birth defect caused by maternal alcohol consumption during pregnancy. The prevalence of FAS in America is estimated to be approximately one FAS baby born in each 750 live births. Recent research conducted by the previous Fetal Alcohol Syndrome of the AIPC and the Indian Children's Program in Albuquerque, shows evidence that the incidence of FAS among American Indians is higher, one in every 633 babies overall, with some tribes as high as one in 100.

Further, mild to moderate alcohol consumption may also damage the unborn in other, more subtle ways. The prevalence of FAS may make it the most common recognizable birth defect among both Indians and Whites.

Because women who do not drink alcohol during pregnancy are at no risk for having an FAS child, the possibility of preventing this birth defect through extensive public education in Indian country is enormously encouraging. Further, research has found that fetal alcohol damaged Indian babies are born to a relatively small number of women. Therefore, identification of these women and intervention efforts hold great promise.

The National Indian FAS Prevention Program has trained a spectrum of people in FAS, its history, its etiology and prevention strategies. The major focus is to spread the current state of knowledge to local areas through the training of two types of expert trainers: (1) FAS clinical specialists for each IHS area, and (2) a minimum of ten prevention trainers in each IHS service unit and/or reservation. These trainers are selected from programs dealing with Indian health, alcoholism, education, social service, maternal and child health, health education, child welfare, and headstart programs. We work with local officials and leaders in selecting the people to be trained.

The National Indian FAS Prevention Program also serves as an on-going resource center. New health education and resource materials are being developed which include pamphlets, posters, a bibliography, a training outline, news releases, a resource guide, an FAS glossary, and copies of selected articles on Fetal Alcohol Syndrome. We are happy to provide all types of information on Fetal Alcohol Syndrome and related topics.

We endeavor to work with all interested health, tribal and community leaders to insure that the next generation of every tribe is the healthiest yet.

Accomplishments to date include:

(1) We trained 35 clinical and prevention specialists from each of the 10 IHS Area and Program offices. We work with these specialists to coordinate the training for prevention and the clinical services needed by FAS children in their administrative areas.

(2) We have trained local prevention trainers in 91 Service Unit locations (there are a total of 92) across the country from Maine to Southern California, Alaska to Louisiana. We are going to do one more on this contract. Each of these sessions lasts a full day.

(3) We have trained over 1900 trainers in FAS recognition and prevention. Most are actively pursuing prevention in their Service Units and/or communities. We have data indicating that their work is being well received.

(4) We have trained an average of 21 trainers per session with an average evaluation score of 4.5 out of a perfect 5.0.

(5) People trained come from IHS clinics, BIA Contract and public schools, CHR, alcoholism, mental health, WIC, Head Start and other programs. Their diversity should help them reach a broad spectrum of the population.

(6) We continue to serve as a support center for trainers and all interested people serving Indian populations. We distribute free pamphlets, posters, fact sheets and other information on FAS. We have distributed over 5000 posters and approximately 120,000 pamphlets to date. We designed 10 different pamphlets and 6 different posters to impart the message in a variety of ways and to reach the various tribes in culturally sensitive ways.

(7) We are currently working to evaluate the effectiveness of our trainers training by helping them document the retention of important information in the populations in which they are training.

(8) In all we find that FAS is an extremely well received topic and an excellent vehicle for prevention. The fact that it is a totally preventable birth defect which is afflicted on the innocent seems to motivate people greatly. Using the above strategies, this motivating factor and local expertise allows us to pass along prevention knowledge and efforts to the local communities where it can be implemented.

For more information on our previous efforts, see the attached journal articles.

May, Philip A. and Karen J. Hymbaugh. "A Pilot Project on Fetal Alcohol Syndrome Among American Indians" Alcohol Health and Research World, Volume 7, Number 2, Winter 1982-83, pp 3-9.

May, Philip A.; Karen J. Hymbaugh; Jon M. Aase; and Jonathan M. Samet. "Epidemiology of Fetal Alcohol Syndrome Among American Indains of the Southwest." Social Biology, Volume 30, Number 4, 1983, pp 374-387.

For more information of any other nature please contact our office directly.

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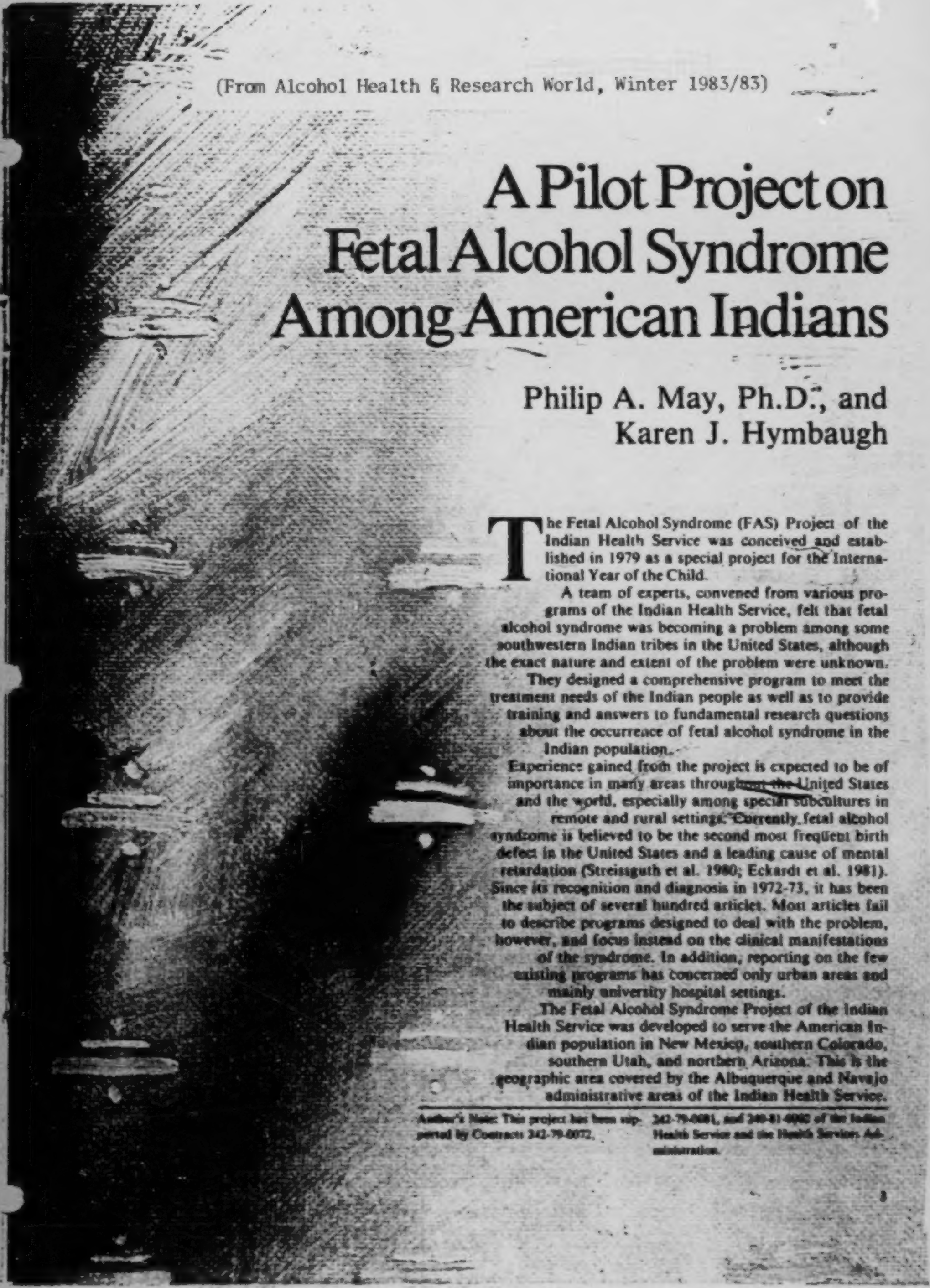
(From Alcohol Health & Research World, Winter 1983/83)



A Pilot Project on Fetal Alcohol Syndrome Among American Indians

Philip A. May, Ph.D., and
Karen J. Hymbaugh

The Fetal Alcohol Syndrome (FAS) Project of the Indian Health Service was conceived and established in 1979 as a special project for the International Year of the Child.

A team of experts, convened from various programs of the Indian Health Service, felt that fetal alcohol syndrome was becoming a problem among some southwestern Indian tribes in the United States, although the exact nature and extent of the problem were unknown. They designed a comprehensive program to meet the treatment needs of the Indian people as well as to provide training and answers to fundamental research questions about the occurrence of fetal alcohol syndrome in the Indian population.

Experience gained from the project is expected to be of importance in many areas throughout the United States and the world, especially among special subcultures in remote and rural settings. Currently fetal alcohol syndrome is believed to be the second most frequent birth defect in the United States and a leading cause of mental retardation (Streissguth et al. 1980; Eckardt et al. 1981). Since its recognition and diagnosis in 1972-73, it has been the subject of several hundred articles. Most articles fail to describe programs designed to deal with the problem, however, and focus instead on the clinical manifestations of the syndrome. In addition, reporting on the few existing programs has concerned only urban areas and mainly university hospital settings.

The Fetal Alcohol Syndrome Project of the Indian Health Service was developed to serve the American Indian population in New Mexico, southern Colorado, southern Utah, and northern Arizona. This is the geographic area covered by the Albuquerque and Navajo administrative areas of the Indian Health Service.

Author's Note: This project has been supported by Contracts 242-79-0072, 242-79-0081, and 240-81-0002 of the Indian Health Service and the Health Services Administration.

Indian groups served include the Navajos, Apaches, Pueblos, and Utes. In 1980, about 240,000 Indians lived on 26 reservations in the areas.

The socioeconomic status of the southwestern Indian tribes varies, for they represent cultures in various stages of transition (Kunitz and Levy 1981). Many young Indians are upwardly mobile through recent educational and economic gains, but the majority of the individuals and tribes served have little advanced education and few economic assets. Increased resource development, on reservations and in the Southwest, has wrought drastic changes in the social and cultural systems of these tribes.

The land area on which they live is vast—over 150,000 square miles (figure 1). The Navajo reservation alone is larger than the State of West Virginia. Although most travel can be done by car, a small charter plane is required to reach some outlying areas. Within the Indian Health Service system, 11 hospitals and 10 clinics in various locations serve as contact points for the project.

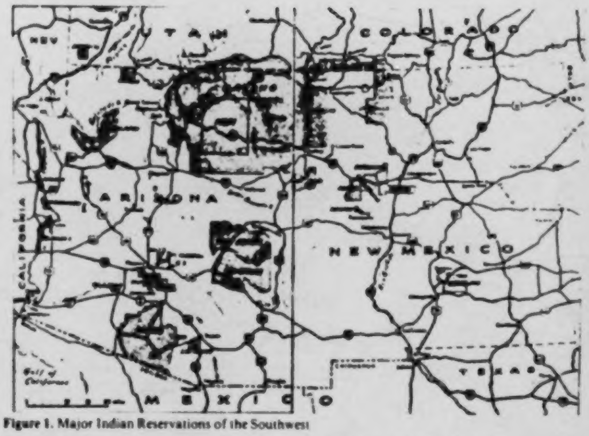


Figure 1. Major Indian Reservations of the Southwest

The project was designed with several objectives. Treatment efforts were to emphasize clinical diagnosis. The purpose of diagnosis was to identify the clinical manifestations of FAS in Indian children, develop a treatment plan, refer children to available resources, and prevent further FAS births (table 1). Training of clinicians, outreach workers, and community groups was to focus on the recognition and prevention of fetal alcohol syndrome. Research efforts were designed to assess the incidence and prevalence of the syndrome among Indian children, determine its etiology, and use this information to develop prevention strategies.

Staff

The FAS Project staff consists of four regular staff and two consultants: a half time director (Ph.D.), two full-time field coordinators (B.S. and A.A.), a full-time secretary, and two consultant dysmorphologists (M.D.). Teamwork is necessary, as is a thorough knowledge of both the Indian Health Service and the local tribal systems. Two of the staff are Indians from the local area, and all staff have considerable experience in Indian health care on local Indian reservations.

The director oversees all aspects of the project, from training and research to relationships with agencies and tribes and administrative matters. Professional experience in epidemiology, field research, and community health is needed. The director is responsible for much of the training of a variety of individuals, from physicians to outreach workers.

The two field coordinators provide all project services in their assigned geographic area. Training of local outreach workers and citizens is a major duty of the field coordinators. They also coordinate all clinics in their assigned area and keep track of all patients from these clinics. Development of program materials and dissemination of all types of information (pamphlets, posters, articles, and advice) is a constant activity. On one reservation (Navajo) translation of materials into the tribal language has been important, and on all reservations a sensitivity to cultural differences has been vital.

The consultant dysmorphologists, pediatricians who specialize in birth defects and anomalies, are indispensable. In addition to the key role they play in diagnosis of the children, their clinical knowledge has been invaluable. All initial training of clinicians was conducted by the dysmorphologists. The director and field coordinators were apprenticed to the dysmorphologists in these sessions and eventually began to assume most of the responsibility for the training of other target groups. In addition to clinical information, epidemiological, social, and counseling information has been added to the training when appropriate. Although different levels and types of training are used for different groups, the initial core of information was established by the dysmorphologists. The dysmorphologist, with minimal assistance from others, is ultimately responsible for each child's treatment plan.

Treatment

The clinical phase of the project has had several objectives. The committee of experts who established the FAS project felt that it was important to determine and document if FAS children in the Indian population of the Southwest differed clinically from other FAS children reported on in the literature.

Little information exists on the treatment of FAS children, and therefore, thoughtful formulation of treatment plans was a priority. Each treatment plan was to guide the coordination of all treatment and rehabilitation efforts for that child, and to help the child develop to the fullest potential. Once the treatment plan was formulated, the child was to be referred to the parent organization of the project, the Indian Children's Program. A multidisciplinary team of specialists (table 2) would then provide care and treatment, focusing on working with the child's specific problems and working toward eventual habilitation. Whenever possible, treatment and habilitation were to be carried out near the child's home using local resources.

The clinics were conceived as providing a unique opportunity to work with the mothers of these children. Ideally, the mothers, parents, or guardians would attend the clinics with their children, where they would be counseled regarding future pregnancies and care of the existing FAS children. The clinics also were seen as a way to provide specific, on-site training for local clinicians in the diagnosis of fetal alcohol syndrome. Since the diagnosis is a complex and multivariate one, firsthand experience under the supervision of experienced persons was considered vital for local clinicians.

The referral system. The referral system has been critical to the project. Because the area served is vast, the system has to be well conceived and dynamic. As shown in figure 2, a suggested pattern or chain of referrals has been set up that begins with referral in the local community and ends with treatment of the child.

A variety of informative materials have been developed by project staff as aids in referral and other areas of activity. Two Indian-oriented pamphlets were designed to inform the public about alcohol damage to the unborn. One is simple for the less educated; the other is more detailed for those with at least a high school education. Another pamphlet for health personnel describes the services of the FAS Project. Four posters have been used extensively. They relay the simple idea that alcohol can damage unborn babies, by means of themes and motifs from local Indian cultures.

Identification of children with problems is initially made in local communities, clinics, and hospitals. Then referral usually is made to one of four designated professionals at each clinic or hospital service unit—generally physicians (pediatricians or general medical officers) or nurses (clinic supervisors or public health nurses)—using forms with a checklist of the features of fetal alcohol syndrome. The professionals designated to receive referrals have exhibited a particular interest in FAS and have been trained through lectures and clinics by a consultant dysmorphologist from the project. The professionals make tentative diagnoses, help set up clinics, and ensure clinic attendance.

Clinics are generally scheduled when a minimum of four suspected cases of FAS have been identified in a particular location. They are held in the local facilities (hospital or clinic), with the help of a consultant dysmorphologist and one or more FAS Project staff. After chart review, discussion, and 1/2 to 1 hour spent with the patient, a final diagnosis is made, and a specific treatment plan is completed.

In the initial planning of the project, the clinics were not named. One FAS staff member, searching for an accurate, yet sensitive, way to refer to the clinics, began calling them simply "developmental clinics." This name has proved useful and has been consistently used by project and local staff to describe all of our clinics. It is also accurate, for a variety of patients with

Table 1. Goals of the Fetal Alcohol Syndrome Project

Training in the recognition and prevention of FAS and all prenatal alcohol damage. Target groups include—

- Clinicians
- Outreach workers—Public health nurses, alcohol counselors, Headstart teachers, community health representatives, etc.
- Community groups—Tribal councils, schools, local units of government, etc.

Clinical diagnosis of developmentally disabled children who are suspected of having FAS. The purpose of this diagnosis is—

- To determine the clinical manifestations of FAS in Indian children
- To provide a treatment plan that can be carried out to promote each child's optimum development
- To refer children to the Indian Children's Program or other resources for needed services
- To prevent further FAS children

Research to better define the nature of alcohol damage to unborn Indian babies. Specifically addressed are—

- Incidence and prevalence
- Etiology (medical and social)
- Prevention strategies

Table 2. Indian Children's Program Multidisciplinary Team

Clinical psychologists
Developmental psychologist
Speech therapists
Developmental pediatrician
Occupational therapists
Physical therapists
Art therapist
Vocational rehabilitation therapist
Educational diagnosticians
Social workers
Recreational therapist
Child psychiatrist

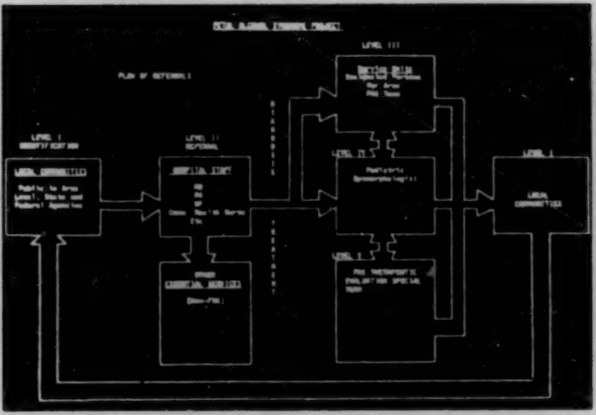


Figure 2. Fetal Alcohol Syndrome Project

diagnoses in addition to FAS and alcohol-related ones have been seen. Regardless of the ultimate diagnosis, any child needing further special treatment or attention receives a treatment plan.

All clinics are directed by a dysmorphologist, and in each a team approach is used. Project staff and local clinic personnel perform support duties such as taking basic measurements (length, weight, and head circumference), giving a Denver Developmental Screening Test, taking a brief medical and social history, and collecting pictures for files. Approximately 1 hour is spent with each child. Several people work together in the initial screening, and one, two, or three staff people generally are present during the dysmorphologist's examination. The main focus of the clinic is obviously on the needs of the child, but an equally important part of each clinic is the training of staff. While the FAS staff learns more from the local staff, about local conditions and patients, they teach the local clinicians some of the finer and more subtle points of the clinical evaluation and habilitation of FAS cases and other birth defects and developmental disabilities. Teaching further cements the bond between project staff and local clinicians.

When the examination summary and treatment plan are typed, copies are transmitted to the child's chart at the local service unit. Copies are also retained by the FAS Project staff and presented to the Indian Children's Program and other appropriate treatment agencies and personnel. Treatment and evaluation is coordinated by the Indian Children's Program, using a multidisciplinary team. The team provides the needed services to the child, refers the child to appropriate resources if they are not available within the team, and teaches local people—both lay and professional—the special techniques needed to care for the child. All treatment is carried out in the local community whenever possible.

From initial referral to followup, the cooperation of various types of professionals and laymen is vital. It is imperative that some flexibility and variability be allowed in the referral system to assure that the particular needs, conditions, and circumstances of the local clinics and people involved are taken into consideration. Project needs must be met in a manner that does not interfere with the work of the local clinic.

It has been vital that the FAS Project serve as the ultimate coordinator and assume ultimate responsibility for treatment of the children. A particular advantage has been the sharing of research data and findings, both from the project and from the literature, with all participants in the referral system.

Clinics. From the first clinic in March 1980 to the end of the project on March 3, 1982, 22 clinics were held in 16 different locations (table 3). More are planned for the future, but await funding.

The average number of children seen per day is 9 or 10. In addition to those recorded in table 3, a number of other children were seen briefly at these clinics for other reasons, such as being siblings of suspected FAS children.

The breakdown of diagnoses indicates that 28.9 percent of all children seen in clinics had the full fetal alcohol syndrome, 15.4 percent experienced a milder degree of damage or fetal alcohol effect, and in another 6.1 percent, findings were "suspicious." For a diagnosis of fetal alcohol syndrome to be made, specific criteria must be met: (1) significant prenatal and postnatal growth deficit, (2) mental deficit, (3) facial dysmorphia, (4) physical abnormalities, and (5) documentation of maternal alcoholism. A diagnosis of fetal alcohol effect (FAE) indicates a milder form of prenatal alcohol damage in which the child has virtually all of the features of fetal alcohol syndrome but in less severe form. A "suspicious" diagnosis denotes that the child meets many of the criteria for fetal alcohol effect, except for insufficient documentation of an abusive maternal drinking history. In general, all FAS diagnostic "labels" are applied conservatively and sensitively, with the major focus being on future therapy.

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In general, the pattern of malformations found in the different Indian groups is quite consistent with that found among individuals of other ethnic groups (Aase 1981).

The remaining 50.4 percent of the children were diagnosed as normal or as having another type of birth defect or anomaly. Other diagnoses included Down's syndrome, hypoparathyroidism, fetal hydantoin syndrome, and Noonan's syndrome. Other types of developmental problems were referred to the clinics so that the dysmorphology services could be used. Some of these referrals were made for anomalies similar in appearance to FAS, but others were totally unrelated and were made simply because the service was needed.

The clinics have successfully provided needed diagnostic services for 230 children. They have been well attended, indicating the success of the referral system. The finding that 44.3 percent of the children referred are definitely suffering from some degree of prenatal alcohol damage is another indicator of a successful referral system. The clinics also seem to have helped create and maintain an interest in a variety of developmental disabilities. Providing an underserved area with a needed specialty has been very gratifying to all.

Training

The training of clinicians and outreach workers primarily was designed to aid them in the referral of suspect children for diagnosis and treatment and to use their knowledge in preventive counseling with clients. Major hopes for prevention, however, were focused on the community training sessions involving tribal councils, schools, and local government units. Since fetal alcohol syndrome is a preventable birth defect, educating people of all ages in the community about FAS was considered vital. If people could be made aware that alcohol causes developmental defects, primary prevention would be possible.

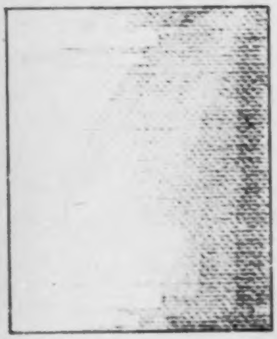
From the beginning of training in January 1980 to March 3, 1982, 232 training sessions were held. In these sessions, 11,123 people were trained by three FAS project staff members and two consultant dysmorphologists (table 4). Of the 11,123 persons trained, 9.3 percent (1,033) were clinicians, 26.7 percent (2,978) were outreach workers, and 63.9 percent (7,112) were community members, primarily students. The average number of people trained per session was 48.

Participating physicians, nurses, pharmacists, and physician assistants generally receive 2 to 2.4 hours of continuing education credits. Community training sessions are less detailed than clinical sessions and rely more heavily on films and discussion than on lecture. In remote parts of the Navajo reservation, sessions often are conducted in the Navajo language through a community interpreter or the Navajo field coordinator. Community sessions are uniformly well received by young and old and do not meet with the resistance generally associated with alcohol-related presentations. In fact, the FAS presentation usually allows for discussion of other, normally controversial alcohol-related topics and issues in a constructive and relaxed atmosphere.

In addition to formal training sessions, posters and pamphlets designed by the program staff increase exposure to fetal alcohol syndrome information. Approximately 7,000 posters and 55,000 pamphlets have been distributed. Films have been important media for the program. In the second year of the project, 40 copies of four different training films on FAS have been continuously on loan to interested parties, such as parent-teacher groups, prenatal classes, health organizations, and schools.

Other materials designed by the program staff that have been widely distributed include a bibliography on fetal alcohol syndrome and related issues; a resource guide listing films, slides, posters, pamphlets, and other FAS materials; and a training guide. All materials have been distributed among national as well as local Indian groups to assist people in starting their own information sessions, campaigns, and systems.

The training sessions and educational materials continue to be enthusiastically received.



Research

Research efforts were designed to expand knowledge about fetal alcohol syndrome among Indians. At present, the literature on the incidence and prevalence of fetal alcohol syndrome is very scarce. Estimates of incidence exist only for the United States (Streissguth et al. 1980), Sweden (Olegard et al. 1979), and France (Dehaene 1977). In most cases the estimates provided are only rough; detailed, systematic prevalence studies are needed. No reliable estimate exists for Indians (see Aase 1981). Specific goals of the project were to establish incidence and prevalence figures for the entire population and for individual tribes, to understand the etiological factors involved in the development of fetal alcohol syndrome, and to use this knowledge to devise prevention strategies.

The initial research results, although still incomplete, show that the incidence of fetal alcohol syndrome varies among reservations. On some, no fetal alcohol children have been found, while on others there are children with severe problems. The wide variation in patterns of drinking and alcohol-related problems among the different tribes has been described by Levy and Kunitz (1974) in the social science/epidemiological literature on Indians and alcohol use. Tribes with a loose, band-level social organization tend to have a higher incidence of alcohol-related problems than do those with a strict, highly structured tribal organization. In general, FAS distribution follows this pattern, with the more highly structured tribes having the fewest drinking mothers and lowest incidence of fetal alcohol damage (May, in press). The incidence of FAS among southwestern Indians may be higher than that reported in the United States generally. One out of every 1,500 to 2,000 babies born in the U.S. is believed to have FAS, while the incidence of other adverse consequences during pregnancy is estimated to be 20 times that rate, according to Assistant Secretary for Health Edward N. Brandt, Jr., M.D., in Congressional testimony in September 1982. Some of the reservations in the project have a significantly higher incidence of FAS than the general United States population, which cancels out the effect of lower incidence reservations and, therefore, makes the overall incidence slightly higher.

A research finding of major importance is the prevalence of multiple FAS or FAE children being born to one mother. Among the mothers with affected children, 22.6 percent have produced more than one damaged child (average 2.36 per multiple producing mother). This appears to be very unusual, for little documentation of this exists in the literature on the general population. Only one case of FAS-affected twins has been found among mothers in our project. It is important to calculate incidence in two ways: the proportion of damaged babies produced per all births; and the proportion of all mothers producing alcohol-damaged babies. These figures will provide more specific indicators of risk and better insight for prevention.

Ostracism of the drinking mother may play a role in the production of multiple FAS babies. In many southwestern tribes, few women drink. Alcoholic women therefore are not tolerated and are frequently left out of regular social interaction. The consequence is almost total lack of social control over their behavior. These women generally migrate to border towns where their only friends and associates are other alcoholics—a setting where there is little stigma attached to the production of multiple FAS children.

Other data indicate that mothers who produce alcohol-damaged children are at high risk in the social sense. A high percentage of the FAS children are in foster placement (see table 3), a high percentage of the mothers are deceased (21 percent), and most mothers have extensive clinic records for alcohol-related problems such as accidents, trauma, and alcohol withdrawal.

Table 3. Diagnosis of patients in developmental clinics by sex and foster placement, March 1980 to March 3, 1982.

Diagnosis	Total	Percent	Male	Female	Foster Placement	Percent
FAS	66	28.9	35	31	48	(72)
FAE	35	15.4	24	11	26	(74)
Suspicious	14	6.1	5	9	10	(71)
Other/Not FAS	115	50.4	66	47	64	(57)
Total	230	100	130	98	98	(65)

Note: 24 clinic days; average 9.56 patients per clinic day.

Table 4. People trained by the Fetal Alcohol Syndrome Project by occupation, January 1980-March 3, 1982.

Occupation	Number	Percent
Clinicians	1,033	9.3
Outreach workers	2,978	26.7
Community persons	7,112	63.9
Students (h.s. or below)	(6,322)	(56.8)
Others	(790)	(7.1)
	11,123	100

Note: Average (mean) per session = 47.9 Clinical and outreach worker sessions are generally smaller than this average.

Conclusion

This paper describes a comprehensive program designed to study and deal with the problem of fetal alcohol syndrome among Indians in the southwestern United States. Training and education, clinical diagnosis and treatment, and research and prevention are all components of this project. Each part of the project has been designed to allow for a variety of complementary efforts.

The project depends highly on interaction and cooperation among community and medical interests. Although the project described here can be used elsewhere with success, it must be innovatively, flexibly, and humanistically adapted to local circumstances. In other words, this system is a guide that directs and focuses efforts. It can and should be varied from time to time to meet the needs of local health providers, communities, and other cooperating interests.

The services of such a project can easily be offered to communities in a sensitive and nonthreatening way. These services seem to help build a relationship that spans the gap between the project and local concerns and creates a new awareness of FAS and of developmental disabilities in general.

It is unlikely that a program omitting any of the strong training, clinical, or research effort would be nearly as effective. Results from the program serve as evidence that it works. A vast number of people have been trained. Many children have been referred and diagnosed appropriately. And finally, the research effort has provided new, exciting, and accurate information that will aid in future understanding, intervention, and prevention.

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Epidemiology of Fetal Alcohol Syndrome Among American Indians of the Southwest

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ABSTRACT: The epidemiological features of Fetal Alcohol Syndrome (FAS) were examined among American Indians in the southwestern United States. All FAS suspects were screened in specific populations of Navajo, Pueblo, and Plains culture tribes. A total of 115 alcohol-affected children were identified. The incidence of FAS was found to be highly variable from one cultural group to the next, ranging from 1.3 per 1,000 births (1/749) for the Navajo to 10.3 (1/97) for the Plains. The pattern of age-specific prevalence indicates an increase over the past fifteen years. The overall rate of mothers who have produced fetal alcohol children was 6.1 per 1,000 women of childbearing age with a range of 4 to 33 per 1,000. These maternal prevalence rates were important for the accurate prediction of public health risk because 25 per cent of all mothers who had produced one affected child had also produced others. The average per mother was 1.3 alcohol-affected children. Other findings indicate that the mothers of these children led highly disruptive and chaotic lives and were frequently isolated from mainstream social activities. In general, the gross social and cultural patterns of the tribes studied can readily explain the variation in incidence of FAS.

In 1979, the International Year of the Child, the Indian Children's Program of the Indian Health Service (IHS) convened an expert committee to select a public health project of major importance to Indian children. This group decided to establish a Fetal Alcohol Syndrome (FAS) Project for two reasons. First, those with extensive clinical experience among Indians perceived FAS as a new and increasing problem among Southwestern tribes. Second, the early FAS literature had already identified some American Indian children with FAS (Smith et al., 1976).

The resulting FAS Demonstration Project had three goals. First, the program was to provide education and training in the recognition and prevention of FAS for health care providers, human services workers, and local community groups. Second, the program was to offer evaluation by a pediatric dysmorphologist to all FAS suspects and initiate a treatment plan for children with FAS and other developmental problems. Third, research was to be undertaken to assess the incidence of FAS among American Indians. The complete project is described in detail elsewhere (May and Hymbaugh, 1983). This paper will focus on the third goal.

Fetal Alcohol Syndrome refers to a pattern of malformations found in children whose mothers drank alcohol excessively during pregnancy. The most common features are: varying degrees of mental retardation and CNS dysfunction, reduced birth length and weight, microcephaly, hypoplastic midface, growth deficiency throughout life, certain joint abnormalities, frequent cardiac defects, and hyperactivity (Jones et al., 1973; Jones and Smith, 1976; Rosett et al., 1976; Streissguth et al., 1980) Recently, it has been recognized that moderate and/or binge drinking may cause less severe forms of developmental damage. Thus, the teratogenic effect of alcohol can be conceptualized as a spectrum. Heavy drinking may result in the complete FAS, whereas lower levels of consumption may cause lesser mental and growth defects (Rosett, 1974, 1976; Streissguth et al., 1978; Eckardt et al., 1981).

In the U.S. and Europe, FAS is a frequently documented birth defect. Although several hundred clinical and experimental studies of FAS among humans and animals have been published, the epidemiology of FAS has not been well characterized. Data are currently available only for Seattle, Washington (Streissguth et al., 1980), Goteberg, Sweden (Olegard et al., 1979), and Roubaix, France (Dehaene et al., 1977, 1981). Estimates of the incidence of FAS vary from 1 in every 600 babies in Sweden and 1 in 700 in France, to 1 in 750 in Seattle. Fetal Alcohol Effect (FAE), a milder form of in-utero damage, has been reported in France and Sweden with an incidence approximately equal to that of FAS. Each of the above rates is based on cumulative clinical experience and not on a survey of a specific population. FAS documentation is currently not available in large national data bases (Eckhardt et al., 1981) and probably will not be in the near future. The present study is therefore unique in determining the magnitude of FAS in a defined population.

MATERIALS AND METHODS

Indian Groups Studied

The Indians of this study are from three very different cultural and social traditions. The Pueblo Indians have inhabited the southwestern United States for 10,000 years or more. Their traditions emphasize sedentary, pastoral, and agricultural pursuits, and their social integration is matrilineal, complex, and strongly "emphasizes conformity with the larger (community based) group" (Dozier, 1970).

The Apache and the Ute tribes are the Plains culture groups in this study. These tribes migrated to the Southwest approximately 1,000 years ago. The nomadic, hunting, gathering, and raiding tradition of their culture is in many ways a polar opposite to the Pueblo. In Plains culture tribes, individuality is encouraged and some flamboyant behaviors such as risk-taking, drinking, and defiance are tolerated and may be encouraged. The largest permanent level of Plains social organization was traditionally a band of several allied extended families (Schroeder, 1974).

The Navajo cultural traditions are a mixture of the Pueblo and Plains traditions. The Navajo came from the same Plains traditions as the Apache, but in the past three hundred years they have adopted many traits of the Pueblo. Therefore, the Navajo patterns of social integration and behavior regulation are intermediate between the Plains and Pueblo. The Navajo emphasize conformity to group norms, but allow more individualized behavior than the Pueblo (Kluckholn and Leighton, 1962).

The contemporary socioeconomic status of southwestern Indians shows some variation within each culture, for the individual tribal cultures are in various stages of modernization and transition (Kunitz and Levy, 1981). Many young Indians are upwardly mobile due to recent educational and economic opportunities, but the majority of the individuals and tribes are characterized by low education and limited economic development. Nevertheless, the overall differences in social integration still exist and influence behavior as evidenced by alcohol-related mortality statistics. The Plains tribes have consistently higher death rates from flamboyant behaviors such as accidents, suicide, and homicide (U.S. Public Health Service, 1978, 1979; VanWinkle, 1981; Reidy, 1982)

In sum, the three cultural traditions of these tribes generally produce different types of behavior (May, 1982). Particularly, their differing alcohol-related behaviors must be considered in evaluating the epidemiology of FAS.

METHODOLOGY

The study was undertaken in 1980–82 among American Indians of New Mexico, Southern Colorado, Southern Utah, and Northern Arizona. Indian groups served by the project resided on 26 reservations with a total population in 1980 of approximately 240,000 (U.S. Dept. of Health, Education, and Welfare, 1979). Because the land area served was vast, transportation and logistics were major obstacles and determinants of the study design.

An elaborate referral system served as the basis for this study. All research activities were coordinated on each of the outlying reservations from the central office in Albuquerque. The major focal point on each reservation was one of the eleven hospitals or ten full-time clinics operated by the IHS. At each of these installations, explicit and detailed training on the recognition and diagnosis of FAS was provided to all IHS clinical staff by the project staff and two consultant dysmorphologists. These diagnostic training sessions were two-hour slide and data presentations detailing the clinical characteristics of 15 FAS. FAE children from birth to 17 years of age. Further literature on FAS was subsequently provided to trainees. In each session the FAS Demonstration Project was explained, with specific instructions concerning referral of suspected FAS children. To complement the training and facilitate referral, all physicians and nurses trained were provided with a three-page referral form for FAS suspects. Items included on this form were key aspects of the parents' medical and alcohol use histories; birth length, weight, and head circumference of the suspect, and a simple checklist of 29 characteristics generally found in FAS. In addition, the referring clinicians were asked to attach growth charts, developmental test results, and other relevant information.

At each clinic or hospital one or two "designated persons" were the major liaisons with the project. The project staff at the central office worked closely with local staff to review and verify the records of the referred child and of his/her parents. Referrals were encouraged for any child considered suspicious because of clinical features of FAS and a maternal history of drinking. The primary emphasis in ascertainment was on children under 15 years of age. FAS suspects were then scheduled for clinics at the health installation from which they were referred. The project staff and one or more of the project dysmorphologists traveled to the outlying clinic where data collection and diagnostic evaluations were completed.

To standardize the final diagnosis, a weighted diagnostic form was developed for the project by a committee of seven experienced dysmorphologists. The form consisted of 36 separate diagstic items divided into four sections: drinking history, radiologic findings, growth and development, and clinical observations. The section on clinical observations contained eleven subsections: general observations, lateral facial profile, ear, eye, nose, neck, chest, arms, and hands, heart, back, and skin.

Screened children were categorized for project purposes as FAS, FAE, suspicious, or without signs of fetal alcohol damage. Two diagnostic categories, FAS and FAE, were used for definite alcohol damage. For the diagnosis of FAS, all of the following were required: (1) prenatal and postnatal growth deficiency; (2) mental deficit and development delay; (3) facial dysmorphia; (4) physical abnormalities; and (5) documentation of alcohol abuse during pregnancy. FAE designated a milder form of prenatal alcohol damage with the child having all of the features of FAS, but to a lesser degree. A diagnosis of "suspicious" indicated that the child met many f the criteria of FAE, except for ade- uate evidence of abusive maternal drinking. Without exception, all diagnoses were made by two dysmorphologists, who both have considerable experience with FAS and American Indians. The major orientation for the diagnosis was toward future therapy and habilitation of the child (May and Hymbaugh, 1983).

Alcohol histories of the mothers and some fathers were obtained from multiple sources. In most cases, adequate documentation was available in medical charts through notes and visits for alcohol-related illness and trauma. Records of local and tribal police, and social welfare agencies were also consulted. Additional informants, such as clinic and field health personnel, relatives, friends, and social service workers were used to further substantiate the history. A strict quantitative definition of alcohol abuse was not possible. Verification was assumed when all sources were in complete agreement that alcohol abuse was common during pregnancy. Since most of these reservations were quite small and of restrictive residence, these informants were quite aware of the drinking patterns of the mothers.

Population data used in the analysis were derived from Indian Health Service estimates. These estimates were based on 1970 U.S. census data, actual Indian births and deaths, and net county migration (U.S. Dept. of Health, Education, and Welfare, 1979) They were the latest available figures which were age- and community-specific.

Two different rates were calculated to describe the occurrence of FAS and FAE. Prevalence rates for children ages 0–14 were calculated with 1979 population estimates as the denominators. To approximate the incidence of FAS and FAE at birth, the actual natality was reconstructed by combining the 1979 population estimates and mortality experience from life tables.[1] The Navajo data were corrected with a tribe-specific life table (Carr and Lee, 1978), whereas the Pueblo and Plains figures were adjusted with a life table for all U.S. Indians (Indian Health Service, 1975). The incidence was then calculated as the ratio of the total number of cases to the total number of births.

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[1] It would have been preferable to use actual births for the denominator, but this was not possible because tribal affiliation is not recorded on birth certificates and because of the IHS system of aggregating birth date.

The prevalence of mothers who had produced an FAS or FAE child was also calculated. The denominators for these rates were the 1974 estimates of women aged 15–44 years. Since the children ages 0–14 in 1980 were born between 1967 and 1981, 1974 is the midpoint year.

Overall rates in each table were calculated for the entire population covered by the FAS project in the Southwest. These rates were adjusted by the direct method with weights proportional to the representation of each culture in the entire study area.

In the results section data are presented for individual reservations and service units. The specific reservations and tribes are not named to avoid stigmatization. Therefore, the results are reported in a way that cites important identifying cultural information, but pseudonyms are used for the particular subtribes, reservations, or areas studied.

RESULTS

The FAS project held 23 clinics in sixteen different locations. Of the 243 children evaluated, 31.3 per cent had FAS, 16.0 per cent had FAE, and 5.3 per cent were considered suspicious (Table 1). Among the 47.4 per cent diagnosed as not having FAS, most were diagnc as normal. Other specific anomalies were found in 12 per cent of the children examined, including hypoparathyroidism, blepharophimosis and Down, Melnick-Needles, Fetal Hydantoin, Noonan, and Cornelia deLange syndromes.

The average birth measurements of the diagnosed children were consonant with FAS in other populations when compared with standard growth charts. Indian FAS children were small at birth in length (mean = 17.3 inches, predicted = 20), weight (mean = 4.6 lbs., predicted = 7.5), and head circumference (mean = 12.2 inches, predicted = 13.6) (National Center for Health Statistics, 1976). Other studies have shown that normal Southwest Indian babies are heavier and longer at birth (Adams and Niswander, 1968), than those of other U.S. populations. Growth patterns for the first two or three years of a child's life were particularly important in diagnosing this con tion. Some of the children diagnosed as having fetal alcohol effect were "low normal" (e.g., 10th percentile) at birth on standard growth charts, but their growth curves showed inadequate

TABLE 1

DISTRIBUTION OF DIAGNOSES OF PATIENTS EVALUATED IN FAS PROJECT CLINICS

Diagnoses	Total	Per Cent	Male	Female	Sex Ratio*
Fetal Alcohol Syndrome (FAS)	76	31.3%	41	35	117
Fetal Alcohol Effect (FAE)	39	16.0	26	13	200
Suspicious	13	5.3	4	9	44
Other/Not FAS	115	47.4	64	51	125
Total	243	100%	135	108	125

*Sex ratio (males per 100 females).

growth, resulting in a marked "flattening" of the curve and a decline in percentile rank in their first few years.

The detailed epidemiological analyses which follow were limited to the seven service units and reservations where ascertainment was judged to be complete by project staff and local health personnel (Table 2). The fertility rates of these tribes during the past fifteen years were comparable and the age structures of these different reservation populations were similar. In these areas there were 55 FAS children and 30 FAE children (aged 0–14) among a total 1979 population of 51,137 of which 22,963 were aged 0–14. Four alcohol-affected children 15 years or older were also found. The Plains groups have the highest rates, with the Navajos and Pueblos lower. Although the rates vary slightly within each group, those for the Navajo and Pueblo are quite comparable to data from Seattle, Sweden, and France (Streissguth et al., 1980; Olegard et al., 1979; Dehaene et al., 1981). The incidence among the Plains tribes exceeds the upper range of any previously reported rates, but the overall culture-adjusted rates are quite similar to previous studies. Age-specific prevalence rates were lower in the older ages (Table 3), with the exception of Plains reservation N.

One unanticipated finding in this research was the frequent occurrence of two or more alcohol-damaged children born to one mother (Table 4). On the completely screened reservations, 85 FAS or FAE children were born to 65 mothers, an average of 1.3 affected children per mother. Fifteen mothers produced more than one damaged child, among them one set of twins (dizygotic). Variation in the pattern of recurrent affected births were found between tribal

TABLE 2

IRTH INCIDENCE AND PREVALENCE (AGES 0–14) OF FETAL ALCOHOL CHILDREN BY CULTURAL GROUP AND SERVICE UNIT* OR RESERVATION†

CULTURAL GROUP AND SERVICE UNIT OR RESERVATION	FAS Birth Incidence	FAS (All Births)	FAS Preval. in Ages 0–14	FAS & FAE Birth Incidence	FAS & FAE (All Births)	FAS & FAE Preval. in Ages 0–14
Navajo Culture	1.4	(1/690)	1.6	2.2	(1/448)	2.5
Service Unit–F	1.5	(1/655)	1.7	2.2	(1/447)	2.5
Service Unit–W	1.3	(1/749)	1.5	2.2	(1/449)	2.5
Pueblo Culture	2.0	(1/495)	2.2	2.4	(1/408)	2.7
Reservation–W	1.5	(1/660)	1.7	2.1	(1/471)	2.3
Reservation–N	5.9	(1/170)	6.4	7.8	(1/128)	8.6
Service Unit–C	1.9	(1/522)	2.1	1.9	(1/522)	2.1
Southwest Plains Culture	9.8	(1/102)	10.7	17.9	(1/56)	19.5
Reservation–S	10.3	(1/97)	11.3	17.6	(1/57)	19.2
Reservation–N	9.2	(1/109)	10.0	18.3	(1/55)	20.0
Total Culture Adjusted Rate†	1.8	(1/633)	2.0	2.8	(1/427)	3.1

*A service unit is a geographical area served by a single I.H.S. administrative unit, usually characterized by one major hospital or clinic.

†Rates per 1,000.

‡Adjusted by the direct method to the proportion of each culture in the entire Southwest study area.

TABLE 3

AGE-SPECIFIC PREVALENCE RATES FOR FAS AND FAS/FAE COMBINED, BY CULTURAL GROUP AND SPECIFIC LOCATION*

CULTURAL GROUP	FAS Ages 0–4	FAS Ages 5–14	FAS & FAE Ages 0–4	FAS & FAE Ages 5–14
Navajo Culture	3.7	0.5	5.2	1.0
Service Unit–F	4.4	0.3	6.2	0.7
Service Unit–W ...	2.7	0.7	3.7	1.5
Pueblo Culture	4.7	1.1	5.7	1.3
Reservation–W ...	4.1	0.5	5.2	1.0
Reservation–N ...	16.3	2.9	24.4	2.9
Service Unit–C ...	3.7	1.5	3.7	1.5
Plains Culture	11.7	10.2	17.5	20.5
Reservation–S	19.9	6.8	26.6	15.3
Reservation–N ...	0.0	14.4	4.7	26.7
Total Culture Adjusted Rate	4.2	1.0	5.7	1.8

*Rates per 1,000.

cultures, but the differences are not readily interpreted because of small numbers.

The prevalence of mothers with damaged offspring was lowest among the Pueblo and Navajo, and much higher among the Plains tribes (Table 4). These rates are useful in measuring the extent and origin of risk in each population.

Social maladjustment, high-risk lifestyles, and high mean maternal age at birth of the damaged children were characteristic of the mothers in this study (Table 5). Of the fetal alcohol children, 73 per cent were adopted or in foster placement. In most cases, the child had been left with relatives or friends, abandoned, or other neglect was documented. In 23 per cent of the cases, the mother was dead, almost always from accidents, cirrhosis of the liver, or other alcohol-related trauma and illness. There was variation by culture, with the lowest mortality in the Navajo and the highest in the Plains. The screening process used could have increased the proportions of deceased mothers and children in foster placement, if foster parents were more likely to have their

TABLE 4

VARIABLES CONCERNING MOTHERS BEARING MULTIPLE AFFECTED CHILDREN AND MATERN PREVALENCE BY CULTURAL TYPE AND LOCATION

CULTURAL GROUP AND SERVICE UNIT OR RESERVATION	MOTHERS PRACTICING MULTIPLES*	FETAL ALCOHOL CHILDREN PER MOTHER†	MOTHERS BEARING FAS & FAE CHILDREN PER 1,000 WOMEN 15–44 YEARS OF AGE
Navajo Culture	21.4%	1.3	5.3
Service Unit–F	26.7%	1.5	4.9
Service Unit–W	15.4%	1.2	5.9
Pueblo Culture	25.0%	1.4	4.6
Service Unit–W	20.0%	1.4	3.9
Reservation–N	50.0%	2.0	8.0
Service Unit–C	20.0%	1.2	4.5
Plains Culture	28.0%	1.2	30.5
Reservation–S	30.8%	1.3	33.3
Reservation–N	25.0%	1.2	27.9
Total	24.6%	1.3	7.5
Total Culture Adjusted Rate	22.3%	1.3	6.1

*Per cent of mothers who have produced two or more FAS or FAE children.

†The total number of FAS and FAE children divided by the number of mothers producing them.

TABLE 5

SELECTED SOCIAL VARIABLES OF MOTHERS, FETAL ALCOHOL CHILDREN, AND OTHER CHILDREN

VARIABLES	FAS & FAE	Not FAS & Other Diagnosis	Signif. Level*
Children in foster placement	73.3%	42.5%	$p = 0.02$
Deceased mothers	23.1%	15.7%	$p = 0.10$
Navajo	10.7%	5.8%	. . .
Pueblo	25.0%	5.0%	. . .
Plains	36.0%	29.5%	. . .
Average age of mother at birth of FAS child†	29.7	26.9	$p = 0.02$
Navajo	28.1	27.8	. . .
Pueblo	32.6	26.6	. . .
Plains	30.7	26.3	. . .

*Significance level determined by *Z* test. Ellipsis dots indicate significance level not reported because of small numbers.
†Age at delivery for mother was not available for 16 of the 65 mothers of fetal alcohol children.

children evaluated. Mothers bearing FAS and FAE children had a mean age at delivery of 29.7, higher than that of the mothers of the non-FAS children seen and higher than the mean age at delivery for all Navajo mothers (24.8) (Broudy and May, 1983). Of all of the mothers who produced FAS and FAE children, only 18 per cent were under the age of 25.

DISCUSSION

A referral network and clinical screening system were used to identify prevalent cases of FAS and FAE in southwestern American Indian groups. This approach was determined largely by feasibility issues and may have limitations for the epidemiological analyses of this paper. First, the adequacy of case-finding cannot be independently verified. Accordingly, we limited the calculation of prevalence and incidence to the populations where screening was known to be satisfactory. The resulting rates (Table 2) were comparable to or higher than those from other populations (Streissguth et al., 1980; Olegard et al., 1979; Dehaene et al., 1981); thus, bias from incomplete ascertainment appears unlikely. Second, alcohol histories were not obtained directly from the mothers. However, the combination of medical records and community informants was generally sufficiently sensitive to identify abusive drinking during pregnancy. Third, calculation of incidence rates for FAS and FAE required a pragmatic reconstruction of birth numbers. This approach also assumes no deaths among children with FAS and FAE and, as a result, probably underestimates the actual incidence. Fourth, a similarly pragmatic technique was used to calculate the prevalence of mothers who had given birth to an FAS or FAE child (Table 4). Mid-point population figures were used to estimate the numbers of women at risk for giving birth to an alcohol damaged child. Although this approach is relatively crude, the prevalence estimates should provide a satisfactory measure of inter-tribal variation.

With these limitations in mind, the incidence of FAS among Southwestern Indians can be compared to previously reported rates. The Navajo rate (1 per 690 births) and overall rate for Southwest Indians (1 per 633) are lower than that reported for Seattle (1 per 750) and fall between the rates for Roubaix, France (1 per 700) and Goteberg, Sweden (1 per 600). The Pueblo rate of 1 per 495 is higher than those for all the comparison populations. The Plains incidence of 1 per 102 births is much higher than any previous figures reported. The overall incidence of FAS and FAE found among Southwest Indians, 1 per 427, is quite comparable to the estimates from France and Sweden, although the criteria used in this study may be more strict than those used in Europe.[2]

The age-specific rates (Table 3) raise three interesting thoughts. First, the literal interpretation is that the occurrence of FAS and FAE is increasing among the groups, especially among the Navajo and Pueblo. Second, the screening process might have been effective in identifying younger children. Third, fetal alcohol children may have unusually high mortality experience in their early years.

Attention can now be turned to possible explanations for the variability in occurrence of FAS in the three American Indian populations studied. Among the possible explanations for this disparity are innate biological differences among the groups, either in the liability for prenatal alcohol damage or in the metabolism of ethanol itself, differences in the teratogenic agent, or sociocultural differences among the tribes studied.

Biological Considerations

While a number of studies in the past have attempted to show differences between Indians and Caucasians in the rate or extent of alcohol breakdown, no convincing differences have been substantiated. The common stereotype of the "drunken Indian" has not been borne out either in terms of aberrant metabolism of alcohol (Reed et al., 1976; Schaeffer, 1981), liver biopsies (Bennion and Li, 1976), or in the proportion of the Indian population abusive of alcohol (May, 1982). Furthermore, there is no evidence for a genetic component in production of the Fetal Alcohol Syndrome, for the type and severity of its manifestations are identical in Indian and non-Indian children (Aase, 1981). While it would be premature to rule out innate metabolic differences of a subtle kind, or the presence of some environmental or genetic cofactors which influence the occurrence of FA there is presently no valid informatio which points in this direction (Schaefer, 1981).

Substrate Differences

Conceivably, there might be some ingredient in the different alcoholic beverages consumed by different groups which might account for different risks for FAS in offspring of alcoholic women. In previous surveys, the type of beverage consumed had no discernible influence either on the incidence or the severity of FAS in children of drinking mothers. Total alcohol intake seems to correlate best with these outcomes (Iber, 1980), but even this seems to be variable, since more than half of the offspring of severely alcoholic women em to be protected from the effects of maternal alcohol abuse (Jones and Smith, 1976; Rosett et al., 1976; Streissguth et al., 1980). In our study, the usual variety of alcoholic beverages was consumed both by mothers of affected and unaffected children. Also, alcohol is definitely the drug of choice among the adults of the study population (May, 1982; Levy and Kunitz, 1974).

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[2] Personal communication with Ann P. Streissguth, Ph.D., University of Washington, and Kenneth Warren, Ph.D., NIAAA.

SOCIOCULTURAL FACTORS

For the purposes of this discussion, sociocultural factors can be viewed as creating expectations which either foster or inhibit individual drinking behavior and also influence the style of consumption. In considering maternal drinking patterns, four considerations need attention: rate, severity, and duration of alcohol abuse in women of childbearing age, and the timing of alcohol intake in relation to the gestation in question.

National surveys indicate that 60 per cent of all U.S. women consume some alcohol (National Institute on Alcohol Abuse and Alcoholism, 1981), while surveys among the Navajo and Plains tribes show that only 13 to 55 per cent of women drink (Levy and Kunitz, 1974; Longclaws et al., 1980; Whittaker, 1962, 1982). Certain subsegments within each tribe, however, have significant alcohol abuse problems as evidenced by high rates of death from accidents, liver cirrhosis, and other alcohol related causes (US. Public Health Service, 1978, 1979) among Indian men and women (Streissguth, 1980).

In these groups, certain distinct social factors may have a profound influence on the severity of alcohol abuse in women and the resulting incidence of FAS and FAE. While the per cent of population drinking within each tribe influences the findings, drinking style is more relevant to severity of abuse. For example, the highest percentage of drinking women is found among the Plains tribes (50-55%; Whitaker, 1962, 1982), with considerably lower percentages among the Pueblo and Navajo (13-23%; Levy and Kunitz, 1974). As expected, the Plains tribes had the highest incidence of fetal alcohol damage. However, the Plains rate of FAS and FAE (in Table 2) is five (4.9) to seven (7.0) times higher than the other tribes, much higher than would be dictated solely by the proportion of drinkers. This is due to the normative pattern of social regulation. The Plains tribes allow for considerably more individuation of behavior, especially alcohol-abusive behavior (Jessor et al., 1968; Curley, 1967). More Plains women are permitted to follow abusive behaviors, while the low incidence rates of the Pueblo and Navajo exemplify tighter control exercised on individuation and alcohol abuse. Bearing an alcohol-damaged baby is not condoned in the mainstream of any of these tribal groups, but it is more common with the loose social integration of the Plains groups.

Social variables can also influence drinking severity and FAS in some special circumstances. An example from our study clearly demonstrated that alcohol abuse rates can be atypically high at certain times which clearly puts more pregnancies at risk. One small Plains reservation (reservation N) with a high incidence of fetal alcohol problems had received royalties for a number of years from the sale of resources extracted from their lands. Payments of approximately $100 per month were distributed to adult tribal members on a per capita basis. For various reasons, the tribe suspended the payments in the late 1970's, and the prevalence of fetal alcohol syndrome appears to have decreased dramatically (Table 3). Of the fourteen Fetal Alcohol children found on this reservation under the age of 15, only one FAE child had been born after the cessation of per capita payments.

Ostracism from a tribal culture may also affect the severity of alcohol abuse. As in most areas of the United States, female Indian adolescents usually experiment with alcohol, but as they grow into their twenties, societal rules become more strictly enforced. Among the Plains tribes more variation in drinking behavior is afforded women, but among the Navajo and Pueblo a woman who continues drinking is much less likely to be tolerated or accepted, especially among the Pueblo. More clearly than in many societies, traditional Pueblo or Navajo people enforce a definite choice on most of their women—to abstain or to be partially or totally ostracized. Those who continue regular or heavy drinking are removed from participation in most family and tribal activities. Once this occurs, stigmatization fixes their alcoholic life style and promotes increased severity of abuse.

Informants consistently reported the ostracism pattern for mothers who produced two or more children with fetal alcohol damage. They were often characterized as unreachable and far removed from mainstream tribal society. We postulate that ostracism maintains the severity and duration of abusive drinking and thus may explain the birth of multiple affected children to a single mother and also the higher rate of FAS among the Pueblo than among the Navajo. Support for this hypothesis is the ratio of FAS to FAE. The ratio is very different between tribes (Table 4). In the Plains groups there are as many FAE children produced as FAS (approximately 1 to 1), while among the Navajo and Pueblo the ratio is approximately 2 to 1 and 4 to 1 respectively. This variation is consistent with the anticipated effects of ostracism and drinking behavior, since the Pueblo exercise the strongest ostracism and the Plains the weakest.

Ostracism may also prolong the duration of alcohol abuse. Among American Indian groups, the period of childbearing is longer than that of the general population (Broudy and May, 1983). The combination of sustained alcohol abuse and this prolongation of childbearing years increases the risk for FAS. In this study a pattern of successively more severely affected offspring was repeatedly observed. Among the women who produced more than one fetal alcohol child, the later children always we diagnosed as having equal (47 per cent), or more severe damage (53 per cent). Therefore, as long as a mother continued to drink, the degree of severity of symptoms increased with each succeeding child. However, several cases indicated that if a mother quit drinking in subsequent pregnancies, normal children were born.

CONCLUSIONS

The ascertainment method used in this study employed several successive levels of screening for children suspected of having Fetal Alcohol Syndrome. This technique, with a weighted checklist of FAS characteristics used in the final screening, was quite cost-effective and yielded reliable prevalence figures for the three American Indian groups surveyed. While not a guarantee of 100 per cent ascertainment, this approach may prove useful in further epidemiologic studies of FAS and other teratogenic conditions in limited populations to permit assessment of risk and planning for intervention.

Analysis of the data gathered in this study showed consistent differences in incidence and patterns of recurrence of FAS among the three subject groups. These differences were of greater magnitude than expected and can best be explained by the unique social and cultural dynamics of the three populations surveyed. The risk for Fetal Alcohol problems correlates better with the drinking style of each group than with overall figures for alcohol consumption. This is by no means a new concept in alcohol studies (Bales, 1946), but bears particularly important implications for the epidemiology of the Fetal Alcohol Syndrome.

Since FAS cannot be treated after the fact, but can be prevented completely by education and other measures directed at women in the childbearing years (Russell and Bigler, 1979; Rosett et al., 1981; Sokol and Miller, 1980; Streissguth et al., 1983), the ability to define a subpopulation at high risk has great importance as a public health issue (Little, 1979; Little and Streissguth, 1981). Education and intervention efforts can be targeted with greater effectiveness once these factors have been determined, and existing social constraints might be turned to positive uses in supporting efforts at alcohol abstinence in pregnant women. During the course of the study, it became evident that the issue of fetal alcohol damage gained widespread and enthusiastic interest among health workers and the general population (May and Hymbaugh, 1983), in contrast to the indifferent response often generated by approaches to other alcohol-related problems. Since the Fetal Alcohol Syndrome is the most common severe birth defect in the groups surveyed, any potential preventive measures hold promise for a significant reduction in the tremendous social, financial, and personal burdens caused by this disorder.

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Senator **Bingaman**. Ken, why don't you go ahead?

PREPARED STATEMENT OF KEN HUNT, PROJECT COORDINATOR, COMMUNITY ADOLESCENT HEALTH PROGRAM, ALBUQUERQUE, NM

Mr. **Hunt**. Good afternoon, Senator Bingaman and Senator DeConcini. I appreciate the opportunity to appear before you today to talk about one of our projects that we think is real exciting that's going on right now and has been going for the last 2 years.

And that is specifically the adolescent health program which is located—one which is located at Laguna-Acoma High School on the Laguna Reservation, and one that is being implemented and just getting off the ground at Bernalillo High School just north of Albuquerque.

First of all, let me say that I am representing a group of community people from the Laguna area, as well as being a staff member of the University of New Mexico, in which we were able to effect a partnership to carry out this project.

I would also like to say that this particular topic we are discussing here today is very appropriate and is one that is right on target in terms of what we are attempting to do through our program.

As a start for this program, the emphasis actually came from the community, the concern came from the community and the identification of problems among its youth in the community.

And that effort started with—actually with the CHR effort in the communities of Laguna and Acoma, so it is entirely appropriate that this particular bill also address CHR support, and we certainly endorse that support as well.

The community effort resulted in a partnership with the University of New Mexico and the Indian Health Service to begin a program that addressed the needs of the adolescents in this particular community, and among those needs was the need to have services available in terms of the physical concerns of youth, their adolescent concerns, the problems with teenage suicide, alcoholism and drug use.

An effort has been made to address those particular issues through our teen center, which is a center, as I stated, located on campus, and is one which works hand in hand with the local school administrators there. One which is accessible to the students, because our students are bused in from varying parts of the reservation to the school, and therefore is very difficult for them to be able to utilize a program that would be community based as opposed to a school base in this particular area.

The other effort at Bernalillo High School also addresses the same kind of a model, in which we would locate the actual services on the campus of the Bernalillo High School, and the faculty and staff there have been very receptive and very open to this kind of an effort there.

There's a great deal of need there. And we have recently been able to convince the Indian Health Service and the State as well that there was—it would be a very cooperative, beneficial effort if we could get a similar program like that started there.

The Indian Health Service, by the way, has been very progressive in terms of their leadership toward adolescent health of this particular effort. The timing was just about right when our committee, our local committee decided that we needed some help.

And we went to them and they responded very quickly. So in that effort, they were very responsive and have been since then.

Additionally, they've been the leader in trying to attempt to hook up a network with other agencies, including the State, including the Federal Government and other programs to try to form a cooperative effort and trying to address the needs of all these adolescents, particularly at Bernalillo, where we have a cross section of adolescents, not just Indian students, though the Indian students at Bernalillo make up 50 percent of the student population there, so we need a cooperative effort there.

Among the other important link I think is the community effort, the community support that is needed, and especially in Laguna, that effort has been there from the beginning.

I think that one of the recommendations we would make as a result of this bill is that the health education, the health promotion and the disease prevention concept is one that we fully support and one that we can very easily tie into, because those are the kinds of things that we are doing already.

In terms of helping to support what the schools are doing, we have been able to provide inservice training, for an example, for teachers. We've been able to work with teachers to provide some of their health education programs. They've asked us help them plan their health awareness days. We've done things like fun runs and health fairs and those kinds of activities to help support them, so in terms of—in terms of our sort of successful way of working with that, I think we've been able to work very well to achieve some of those things.

Now, I'd also just like to close by saying that I think that there are some barriers that exist between varying agencies, like the State, like the Federal Government, like the University of New Mexico, even. And the problem is trying to break those barriers down, but they need to come down. That's the only way that we can get some of these cooperative efforts working.

There are some very key people at these agencies who are very interested in working with us and with other people and are very concerned about the problem as well.

And it is through and working with those key people in those varying agencies that we've been able to come this far with this particular program, and I think what we need to do is just continue a dialog to identify who those key persons are, and allow them to then work with us in cooperative efforts.

I commend your efforts today in listening to the people that are here and wish you well in the success of this particular bill.

Thank you.

Senator BINGAMAN. Thank you very much, Ken.

[Mr. Hunt's prepared statement, with attachments, follows. Text resumes on p. 251.]

STATEMENT OF KEN HUNT, PROJECT COORDINATOR, COMMUNITY ADOLESCENT PROGRAM, ALBUQUERQUE, NM

Senator Bingaman:

Thank you for the opportunity to appear here today and for your interest in obtaining testimony from those who will be affected by the proposed bill and the effects it will have on the programs with which we are involved. My name is Ken Hunt. I am from the Laguna Pueblo, which is locted 45 miles west of Albuquerque. I am the project coordinator for the University of New Mexico's Community Adolescent Health Programs, Departments of Pediatrics and Family, Community and Emergency Medicine. I represent an effort on behalf of a group of community persons who are very concerned about the health of their adolescents and also represent the university's efforts to respond to the needs of the communities. I would like to address our support for S. 400 in general and specifically to emphasize the needs of our target population, the Indian Adolescent. We believe that our best efforts to work with Indian adolescents can prove successful in the future with respect to health promotion and disease prevention. We believe that if change is to take place, that the efforts to effect that change should begin with our younger populations. Certainly we recognize the need to promote healthy adult populations as well, but in many instances, in working with the adults, we are working with people who have already made some basic decisions about their health or who are already suffering from a chronic disease and require some intervention.

We think that by targeting our efforts at the teenage population, we can make some very direct impacts on the behaviors they will eventually exhibit in the health of their own lives as well as that of their children. We believe that cooperative efforts with the Indian Health Service, the State administered public schools, the local tribal governments, the people of those communities, and an institution like the University of New Mexico can work together to address these concerns. Probably the most important factor in this partnership is the desire on the part of the community and its people to make a change and achieve better health status.

I would like to relate to you our experience in such an effort as an example of what might be achieved and the need to emphasize cooperative efforts, why health education in the public schools is important, and why health promotion and disease prevention is appropriate for the adolescent.

In November of 1982, I was the Director of the Laguna Community Health Representative (CHR) program. Along with IHS community health nursing we began discussing the topic of maternal and child health, especially related to the increasing numbers of teenage pregnancies, its risk factors, and the lack of proper prenatal care, sometimes resulting in complications of pregnancy, ultimately affecting the high cost of deliveries and proper patient care. Our group quickly realized that ours was not only a medical problem, but a social problem as well, that there were many factors present in the community which contributed to the concern and that just addressing teen pregnancy by itself was not going to solve it. Our teens were facing multiple problem areas including cultural dichotomy, alcohol and drug use/abuse, a public school system without input from the local tribal governments, and inadequate information about their own health. Outside support and assitance was sought and with the help of the

IHS, a contract with the University was obtained to address adolescent health concerns. I have since gone to work for the University as the Project Coordinator for these adolescent health programs. Our first school based program opened its doors in March 1984.

The projects with which we are involved are school-based adolescent health programs and involve state of New Mexico public schools. One of these schools is situated on the Laguna Indian Reservation while the other is in a small town just north of Albuquerque at Bernalillo. In Laguna, the Indian student population is approximately 98%. In Bernalillo, it is approximately 50%. The foresight of the Albuquerque Indian Health Service Maternal and Child Health Program enabled the group of local community people, the IHS, and the University to form a unique partnership to work toward a common goal of addressing the health needs of the teen population. Since Indian populations are involved in this effort, there is a natural tendency for involvement by the respective tribal governments. Another link in these efforts has been the very slow participation of state involvement or the recognition that a need exists that the state could help alleviate. We have been able to convince a local private primary care provider to apply for and receive a grant to provide a portion of their services specifically for adolescents. That support came from the state. However, both the Indian Health Service MCH consultant and ourselves have been unsuccessful in our attempts to get the state to match funds with the IHS especially in a public school setting where nearly half the students are non-Indian. So far the IHS has been the leader in efforts to resolve the problems and issues around health care of adolescents. Realizing that the state is not interested in emphasizing their involvement in the specific health care aspect, the opportunity to provide and promote health education in the public schools would have a direct effect on the Indian student populations attending those schools. Health education in the schools is advantageous because students are a captive audience, health education can and should be an integral part of the regular curriculum and it fills a need which is inadequate at present. This is especially important for reservation based schools but is equally important for non-reservation programs. Though many Indian students reside on their respective reservations and commute or are bused to off reservation schools, there are also large Indian student populations which reside in urban communities.

Our programs involve making certain services available to a little over one thousand students in two schools. We expect to add two other schools in the next 1-2 years which will add another eighteen hundred students. Though these numbers may seem insignificant, the potential for directly benefiting these students through a cooperative effort with the state, the IHS, the local schools and health education efforts mandated by the state is tremendous. In those schools with which we are already closely working with, school staff have asked us to help them fulfill their health education requirements by providing speakers and materials for their classrooms, educational materials available to students, rap sessions on various topics, planning and presenting teen health awareness days, health fairs, fun runs, and other health promotional efforts. By working cooperatively with the schools, there is the environment to promote healthy people and change in the future. Through our teen centers we can facilitate and participate actively with the schools. We are limited though by the resources available to us in the community as well as by what the schools have available to them. It is certainly desirable to be able to do more because the need is so great for the populations with which are dealing.

We have included in our written testimony some statistics as examples of the increased health risks of Indian adolescents, especially related to accidents, including alcohol related motor vehicle, teen pregnancy, suicide, and drownings. It is obvious that we are dealing with a high risk target population.

In summary we support:

- that in addition to the provision of primary health care, the Indian Health Service should provide health promotion and disease prevention services to Indians.

- The additions of Sections 202, 203, and 204 to TITLE II of the Indian Health Care Improvement Act.

- That efforts should be made to identify exisitng resources and programs and, where possible, establish linkages between IHS, the Tribal governments, the States, and community groups.

- The addition of Section 107, the Community Health Representative Program to TITLE I of the Indian Health Care Improvement Act. The CHR program was instrumental in the development of our program and continues to be a vital part of the adolescent health program through support and participation in our activities.

- That health education efforts in the public schools will have a direct impact on Indian student populations and that the federal government, the states, and IHS form cooperative efforts to address this need.

- That health promotion and disease prevention efforts focus on the Indian adolescent populations as a means for effecting change in the future health of Indian communities.

- That change can occur in Indian adolescents through health promotion efforts aimed at:
    - reduction in the misuse of alcohol and drugs
    - improvement of nutrition
    - improvement in physical fitnesss
    - decrease in absenteeism

- That change can occur in Indian adolescents through disease prevention efforts targeting:
    - control of sexually transmitted diseases
    - family planning
    - pregnancy and infant care
    - control of accidental injuries

- The development of a health promotion and disease prevention policy for American Indians, and more specifically Indian adolescents since one currently does not exist.

- That a comprehensive health promotion strategy through education, especially of the Indian adolescent, be developed.

- That a single demonstration project is not enough. Because of the diversity of the Indian populations, several projects are needed.

In closing, we ask that you consider as well the special needs and the high risks of adolescents in your deliberations. We consider our young people our future and it is for them that we are here today.

We applaud your efforts on behalf of all Indian people and appreciate the opportunity to appear before you today. Thank you.

New Mexico Statistics Regarding Adolescents
compiled by Teen Center Projects
Sally Davis & Ken Hunt
May 1985

•At its 1981 level of 1,3331,000 people, New Mexico, the fifth largest state in land area, ranks 37th among the states in total population and is the seventh lowest in population density. It is basically a rural state with a population density of about 11 persons per square mile. According to the 1980 Census there are in New Mexico only six cities with populations in excess of 30,000 people.

•Ethnically, New Mexico's population is composed of four major groups: non-Hispanic White comprise 52.6% of the States's population; the Hispanic 36.3%; the Indian 8.1%; and the Black 1.8%. By percentage, the Indian and Hispanic comprise larger portions of the total population than in any other state. The Indian is the fastest growing of the State's ethnic groups. It is also a young population with 60% being under 25 years of age.

•Although monetary income is not the sole determinant of the quality of health, "low income people in general have worse health than people of higher income" (DHEW report, Health-United States, 1976). New Mexico's personal income ranks forty-second among the states. New Mexico's 1980 per capita income figure of $7,878 was 17% lower than the national figure of $9,511, dropping to 19% lower in 1981. A greater percentage of persons in New Mexico are at or below poverty level compared to the total U.S. population. According to the 1980 census, 17.4% of the people in New Mexico are at or below poverty level compared to the national figure of 12.5%. The percentage of persons in New Mexico at or below the poverty level is 39% greater than nationally. Over 40% of the Indian and nearly 1/4 of the Spanish origin populations in New Mexico are at or below the poverty level, and as stated earlier, percentagewise, these two groups comprise larger portions of the State's total population in this state than in any other.

•Nearly twice the percentage of deaths in New Mexico occured to persons under age 35 years of age than did nationally. Of the deaths occurring nationally, 8.5% were persons under 35 years. In New Mexico, 14.7% were under age 35. Among the Indian population, the percentage of deaths for males under 35 was 40.1%, and for females, 31.4%, the highest in this age group as compared to the State's other ethnic populations.

•One factor contributing to these high percentages of younger deaths in New Mexico is of course the State's young population structure. Also, the high rate of mortality in the State for causes such as accidents, normally associated with younger age groups, would lead one to suspect higher rates of mortality within these age groups

•Like nationally, accidents are the leading cause of death in ages 5 to 24. The accidental mortality rate and overall mortality rates in the State are generally higher than corresponding national figures for all New Mexico race/ethnic groups. Motor vehicles were involved in a greater percentage of New Mexico accident fatalities than nationally. Mortality rates were higher for males than females in this age group. In the 15 to 24 age group, homicide and suicide follow accidents as the leading cause of death. In New Mexico Indians in this age group alcoholism also ranks as a leading cause of death. Mortality rates for this ethnic group is higher than the national figures for this age group.

•The fertility rate among New Mexico teenagers 15 to 19 is over a third higher than in the United States in general. The fertility rate for Indians is twice that of the U.S. It is a well-known fact that teen mothers are much less likely to come in for prenatal care. Indians also are less likely to receive prenatal care than are other groups.

•Navajos, Apaches and nineteen Pueblo groups comprise the 8.1% of New Mexico's populations and live in five of the State's sounties.

•New Mexico's school dropout rate for 9-12th grade students in 1981-82 was 8.1%; for Indian students it was 13.8%.

•Fifty percent of deaths among 15-24 year olds are alcohol involved.

•In 1979 the Acoma-Canoncito-Laguna (ACL) Service Unit (IHS) reported a suicide rate of 35.0 per 100,000. In 1980, the suicide rate for the Pueblo of Laguna was 46 per 100,000, 3.6 times the national rate of 12.8 per 100,000. Victims are almost all male and most die from self-inflicted gun shot wounds.

•In April of 1985 at Laguna-Acoma Junior/Senior High School, with a total population of 450 students and almost no in or out migration, there were 14 female students who had babies (age 6 mons. to 3 yrs.) and 4 who were pregnant.

LEADING CAUSES OF DEATH FOR 15-24 y.o.'s

AGES 15-24
LEADING CAUSES BY NEW MEXICO ETHNIC/RACE
NEW MEXICO RESIDENTS 1977-79 AVERAGE
UNITED STATES 1978

NEW MEXICO ETHNIC/RACE	RATE/ 100.000 POPULATION		
	TOTAL	MALE	FEMALE
UNITED STATES			
All Causes:	117.5	173.5	60.9
Accidents	64.5	100.5	28.0
(% *Motor Vehicle*)	(71.9)	(70.1)	(78.9)
Homicide	13.2	20.4	5.9
Suicide	12.4	20.0	4.7
Malignant Neoplasms	6.3	7.7	4.9
Heart Disease	2.7	3.2	2.1
NEW MEXICO-All Races			
All Causes:	198.7	315.9	83.4
Accidents	120.0	198.1	43.2
(% *Motor Vehicle*)	(79.4)	(77.5)	(87.8)
Suicide	28.2	49.2	7.6
Homicide	18.7	30.8	6.7
Malignant Neoplasms	7.4	8.6	6.1
Alcoholism	2.6	4.4	0.9
NON-HISPANIC-White			
All Causes:	181.5	277.6	83.7
Accidents	111.2	177.1	44.0
(% *Motor Vehicle*)	(79.0)	(77.3)	(85.9)
Suicide	26.4	44.4	8.1
Homicide	14.4	21.3	7.4
Malignant Neoplasms	8.0	10.3	5.6
Heart Disease	2.8	3.7	1.9
HISPANIC-White			
All Causes:	176.8	292.1	66.9
Accidents	105.7	183.0	32.1
(% *Motor Vehicle*)	(81.1)	(79.2)	(91.3)
Suicide	24.3	43.2	6.3
Homicide	20.7	35.9	6.3
Malignant Neoplasms	6.8	7.3	6.3
Heart Disease	1.4	0.7	2.1
BLACK			
All Causes:	70.0	79.0	76.9
Accidents	14.2	13.2	15.4
(% *Motor Vehicle*)	(100.0)	(100.0)	(100.0)
Homicide	14.2	26.3	--
Heart Disease	7.1	13.2	--
Malignant Neoplasms	7.1	13.2	--
Congenital Anomalies	7.1	13.2	--
[redacted]			
All Causes:	463.2	784.3	175.6
Accidents	285.3	486.3	105.4
(% *Motor Vehicle*)	(76.6)	(74.2)	(86.7)
Suicide	68.6	129.4	14.0
Homicide	37.1	70.6	7.0
Alcoholism	20.4	31.4	10.5
Influenza/Pneumonia	7.4	11.8	3.5

AGE SPECIFIC ACCIDENT DEATH RATES
Rates per 100,000 Population

Accidental death rates experienced by the Indian and Alaska Native population are higher than those of the U.S. All Races rate in all age categories shown below. The largest number of accident deaths occurs to Indians aged 15 to 24 (31 percent of all accident deaths). The accident death rate for Indians and Alaska Natives in this age group is 3.5 times that of the U.S. All Races population. Indians and Alaska Natives 25 to 54 die of accidental causes at a rate about 5 times that of the total U.S. population.

	Indian & Alaska Natives CY 1976-1978		U.S. All Races CY 1977		Ratio of Indians and Alaska Natives to U.S. All Races Rate
Age at Death	Number	Rate	Number	Rate	
Under 1	63	92.6	1,173	37.1	2.5
1 - 4	201	73.8	3,297	27.3	2.7
5 - 14	250	33.8	6,305	17.3	2.0
15 - 24	1,148	216.6	25,619	62.5	3.5
25 - 34	740	223.3	14,593	44.2	5.1
35 - 44	451	175.3	8,867	37.8	4.6
45 - 54	360	176.6	9,427	40.3	4.4
55 - 64	250	168.0	9,740	47.8	3.5
65 - 74	139	148.8	9,006	61.8	2.4
75 - 84	87	227.2	9,178	134.4	1.7
85+	53	423.7	5,908	284.2	1.5

Vital Events Branch
OPS/DRC/IHS
December 1, 1980

NATIONAL IHS STATISTICS
CENTER

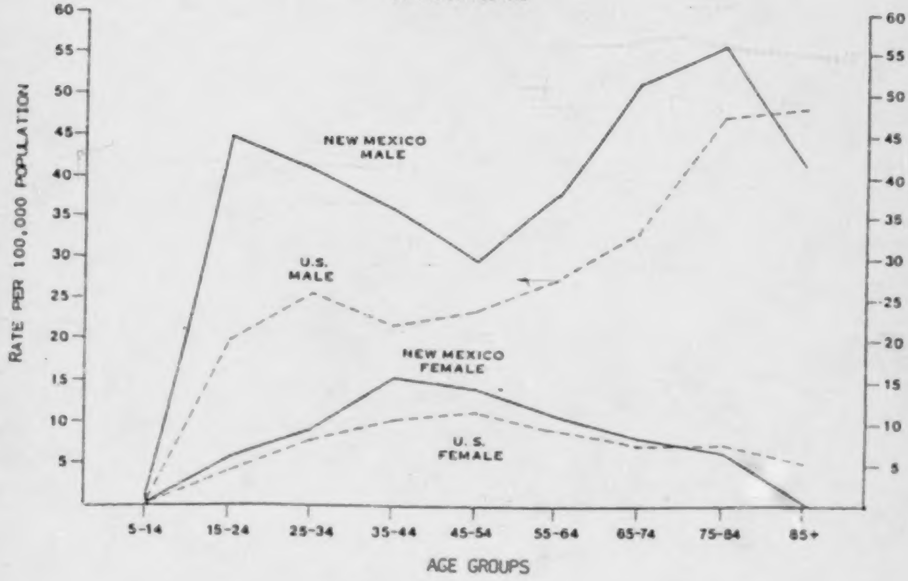
The state's suicide mortality rate for males in the 15-24 age group is more than double the national figure. The rate then decreases to a low for the 45-54 year old males (though still higher than nationally) and then increases with age, with the highest suicide mortality rate being that for males 75-84 years of age.

For New Mexico females the rate increases reaching a peak in the 35-44 age group and then decreases with age. Nationally, female suicide rate is highest in the 45-54 age group.

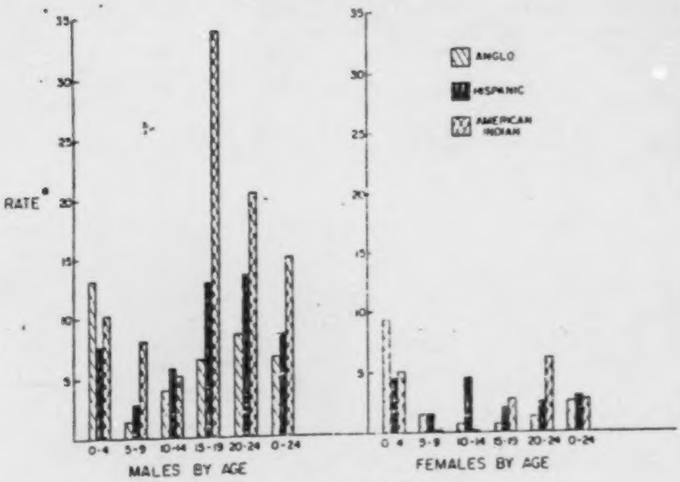
All but two of New Mexico's age groups (75-84 and 85 +) exceed the national rate for female suicides. The pattern variations are: female suicide mortality decreases for older ages, for males the rates increase dramatically; New Mexico males 15-24 have an exceptionally high suicide mortality even considering that the rate for the State's males is generally higher than nationally; suicide mortality for New Mexico women is higher than for women nationally except for women in their seventies and older; suicide mortality peaks at a younger age for women in New Mexico than nationally.

✓ In New Mexico suicide ranks as the third leading cause of death for 5-14 year olds, second leading cause-of-death for 15-24, and second leading for cause of death for the 25-44 age group.

FIGURE 9
SUICIDE DEATHS
RATES PER 100,000 POPULATION
BY AGE
NEW MEXICO RESIDENTS 1979-81
UNITED STATES 1978

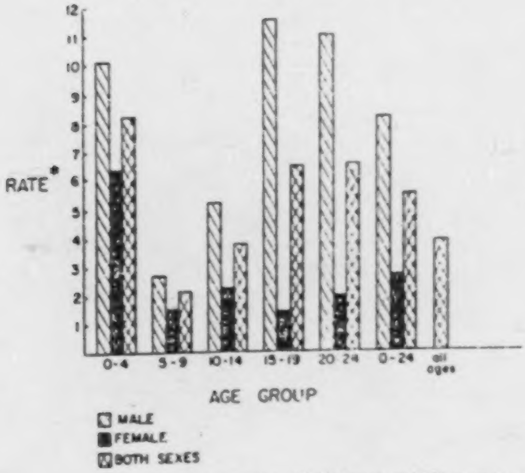


INCIDENCE BY ETHNICITY



*Age adjusted rate per year per 100,000 based on 1975 adjusted census

DROWNING RATES BY AGE AND SEX



*Age adjusted rate per year per 100,000 based on 1977.5 adjusted census

rom a study by S. Davis & J. Ledman

4. Teen Pregnancies in New Mexico

1. **Teens in New Mexico are much more likely to bear children than are teens in the rest of the U.S.**

See Graph 20

The fertility rate among teenagers age 15-19 is over a third higher in New Mexico than in the rest of the U.S.

2. **Teen mothers and their babies face higher health risks than do older mothers and their babies.**

See Graph 21

3. **The babies of teen mothers are much more likely to die during the first year than are the babies of older mothers.**

The babies of teen mothers are more than 1⅔ times as likely to die during the first year as are the babies of older mothers.

See Graph 22

4. **The babies of teen mothers are more likely to have low birth weights than are the babies of older mothers.**

In New Mexico in 1981, 9.3% of the babies born to teen mothers (age 19 or younger) had low birth weights. In contrast, 6.9% of the babies born to mothers age 20-34 had low birth weights. Teen mothers, then, were 1⅓ times as likely to have low-birth-weight babies.

See Graph 23

5. **Teen mothers receive a lower level of prenatal medical care during pregnancy than do older mothers.**

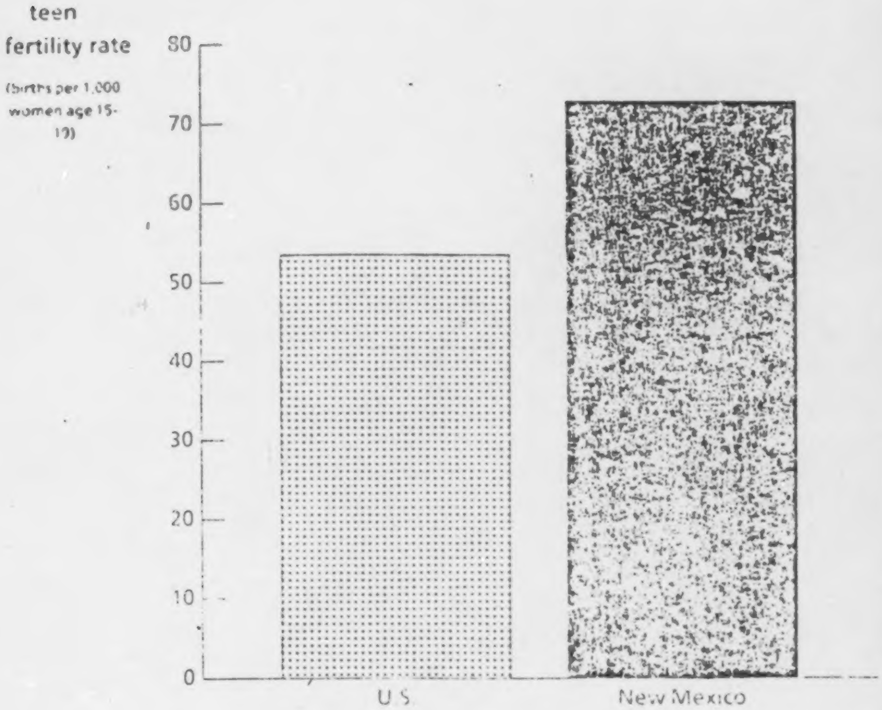
Teen mothers are much less likely to come in for prenatal care during the first three months of pregnancy than are older women.

Where to find related information

For more information on teen pregnancy in New Mexico, please see Graphs 17 and 20-23. More detailed information can be found in Tables 25-30 in the Appendix.

Teen Fertility Rates

U.S. and New Mexico Comparison • 1980

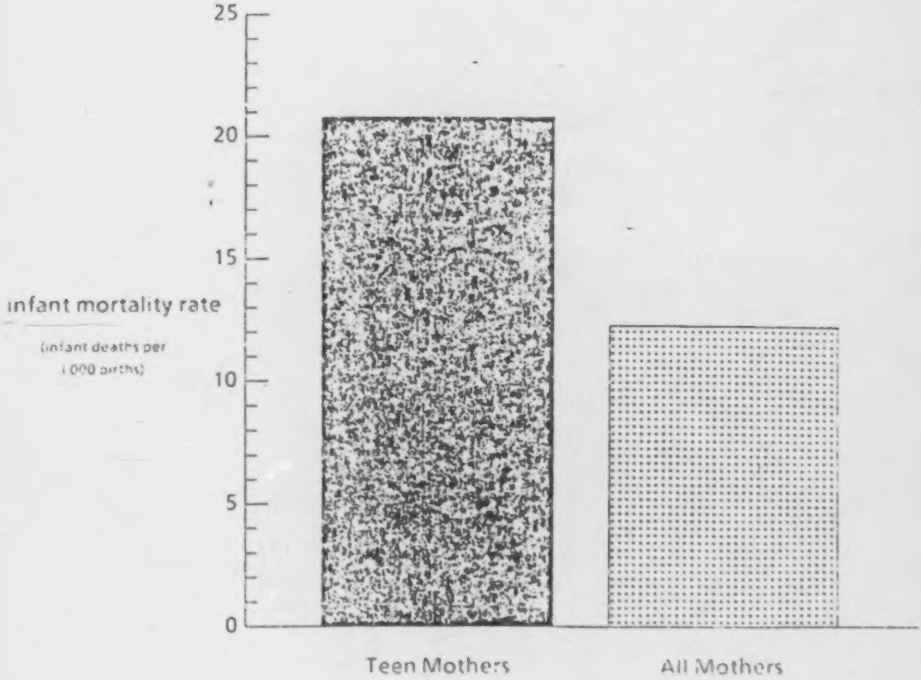


THE FERTILITY RATE OF TEENS (AGE 15-19) IS OVER A THIRD HIGHER IN NEW MEXICO THAN IN THE REST OF THE U.S.

GRAPH 20

Based on Table 27
in the Appendix

Infant mortality as related to Teen Pregnancy



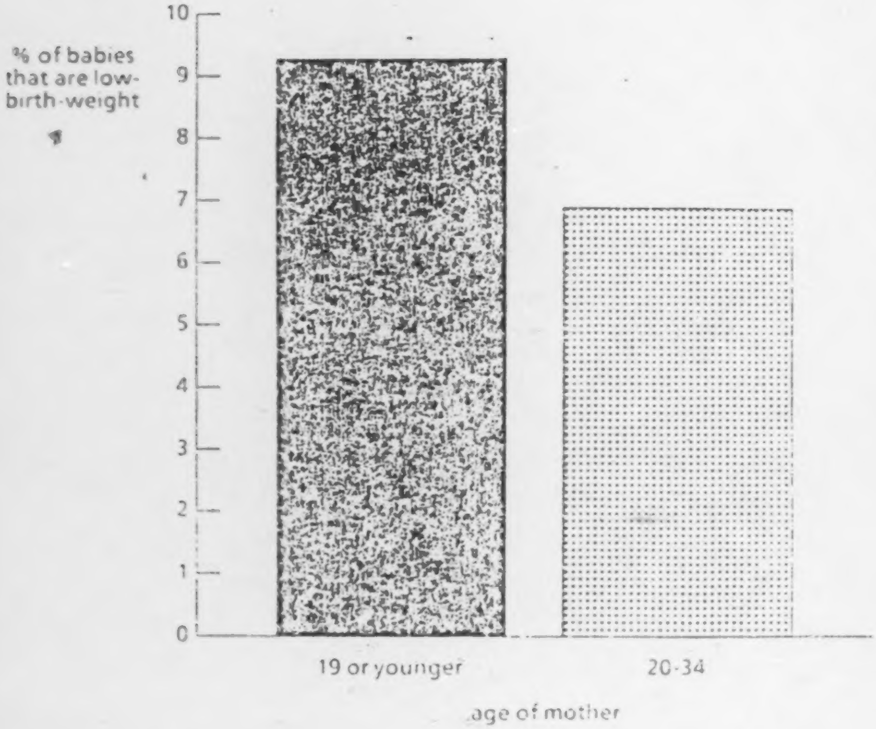
THE BABIES OF TEEN MOTHERS ARE MORE LIKELY TO DIE BEFORE AGE ONE THAN ARE THE BABIES OF OLDER MOTHERS.

Note based on statistics from New York State [illegible]

GRAPH 21

Low birth weight as related to Teen Pregnancy

New Mexico • 1981

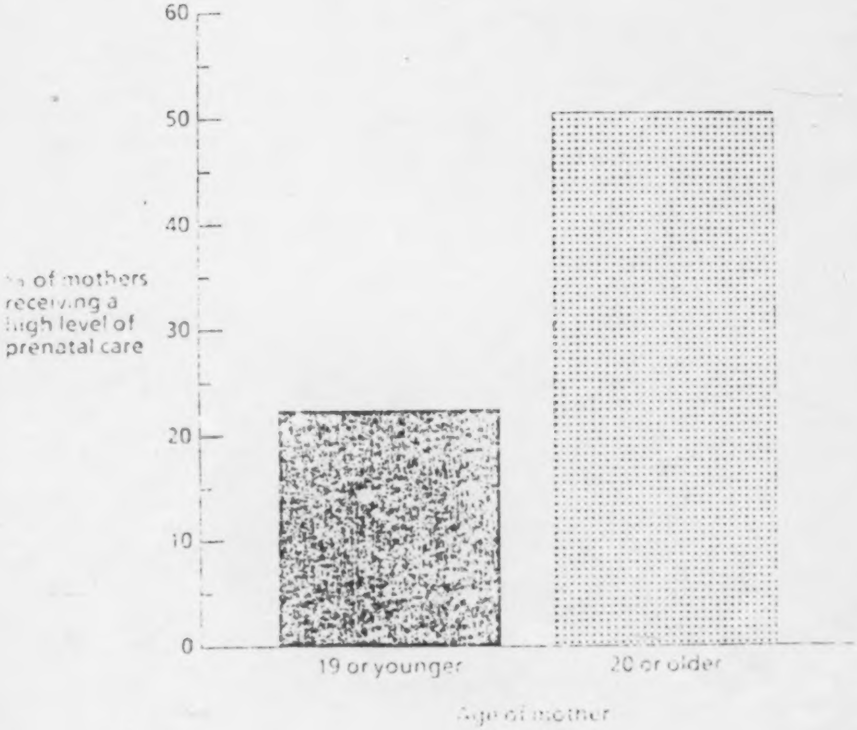


TEEN MOTHERS ARE MORE LIKELY TO HAVE LOW BIRTH-WEIGHT BABIES.

GRAPH 22

Based on Table 29 in the Appendix

Prenatal care of Teen mothers
New Mexico • 1981



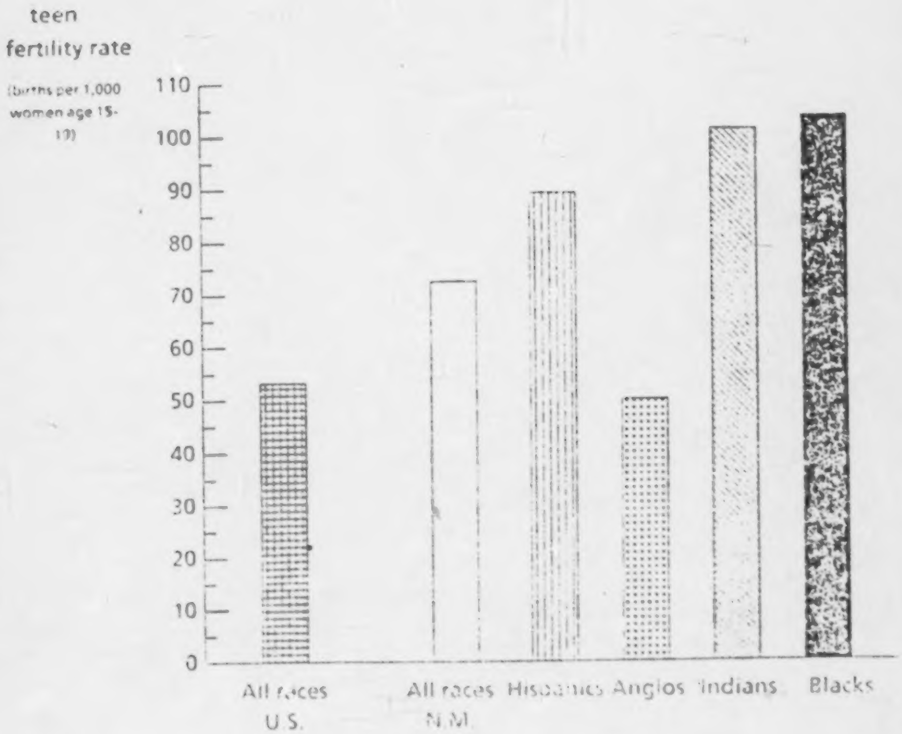
TEEN MOTHERS RECEIVE A LOWER LEVEL OF PRENATAL CARE DURING PREGNANCY THAN DO OLDER MOTHERS

GRAPH 23

Based on Table 30 in the Appendix

Teen Fertility by Race/Ethnic Group

New Mexico Residents • 1981



TEEN FERTILITY IS HIGH AMONG NEARLY ALL OF NEW MEXICO'S RACIAL AND ETHNIC GROUPS

GRAPH 15

Based on Table 26 in the Appendix

Senator BINGAMAN. Senator, go ahead.

Senator DECONCINI. I have a couple of questions. Maybe Cheryl, you can—I didn't get to see your statement, and I don't think I missed it, but you've been involved in this chemical awareness activities for a long time. Can you tell us how serious it is in the school district you're in? What do the figures show there when you came in?

Ms. WATKINS. Ninety percent of our kids by their senior year, drink; 60 percent have tried marijuana. One-third of our students have come to school under the influence of marijuana. Seventy percent start in the seventh and eighth grade. Twenty-seven percent have been directly involved in violence as a result of their own chemical use.

Eighty percent of 11 and 12 graders have ridden in a car where someone was under the influence—the driver was under the influence of alcohol or other drugs.

Senator DECONCINI. How many students have had to be either suspended or quit because of——

Ms. WATKINS. We have a 20-percent dropout rate, and it's estimated 80 percent of those kids are seriously involved with chemicals.

Senator DECONCINI. With chemicals?

Ms. WATKINS. Yes.

Senator DECONCINI. And you said for $7,000 you can put in—what was your word, a premium program, or a——

Ms. WATKINS. A real comprehensive program.

Senator DECONCINI. Comprehensive program.

Ms. WATKINS. I started my program with $1,500. The school district released me one period to coordinate this program—that was covered through other teachers absorbing my class load, so that program actually cost us $1,500. These programs can be done very cheaply and effectively.

Senator DECONCINI. If you had say $7,000, you could do a program, you think, in almost any school?

Ms. WATKINS. Yes.

Senator DECONCINI. And on the reservation as well?

Ms. WATKINS. Yes.

Senator DECONCINI. You don't—and so you're talking about this pilot program under S. 400, that some of that money—starting some of those pilot projects at that kind of cost?

Ms. WATKINS. Yes, sir.

Senator DECONCINI. We're not talking about big money then, are we?

Ms. WATKINS. No, we're not.

Senator DECONCINI. When you put together a program such as you put, what are some of the key components that it takes besides the $7,000?

Ms. WATKINS. The district boards, administrations need to buy into it. The school needs to take ownership of it. Teacher training——

Senator DECONCINI. Do you mean by that they need to accept it and support——

Ms. WATKINS. Yes, sir.

Senator DECONCINI [continuing]. What it is you're going to do?

Ms. WATKINS. Yes. You need to train all your staff. We need to work with the adults, start with the adults and work down. We need a comprehensive program, just not a curriculum. A curriculum is important, but we need to train the teachers. We need to set up support groups, help for kids in school. Once they leave, we lose them, so groups are imperative, especially kids that are busted and children from alcoholic homes.

Senator DECONCINI. Do you involve the parents?

Ms. WATKINS. Parent and community education is real vital. We provide support, information, education for parents as well.

Senator DECONCINI. How do you get the parents involved? Do you go to them, or do you tell the kids to get them to come, bring them down, or——

Ms. WATKINS. We do both. We find when the parents don't come out, we send a lot of information home to them. If we can't get them in, we go to them. A lot of parents call us for help, and we can tell them where help is available, and they don't have to make 10 phone calls.

Senator DECONCINI. You've obviously given some thought to these programs when you got it down to a dollar figure, as you indicated. What kind of thought have you given to trying to do it on reservations? Have you mapped out anything, drawn up anything or been to a reservation school or anything like that to get a feel for it, or are you just taking what you know works and then transposing it on what you think would be the case on the reservation?

Ms. WATKINS. I know that—especially in a K through 6 program, that this basic model has been adapted very, very well to the Indian population. And in my own school district next year plan, I'm doing more specific adaptation with the Indian population in our eight schools. And I have talked to the Phoenix Indian School, which is the boarding school, and have looked into—they do not have any programs there right now, and I want to get with them next year and start working with them in a joint effort to share what I know works on a large systemwide basis.

I do know our program was working with cultural minorities, with our black and Hispanics, has blended in very well. And there are some minor adjustments, but there has not been a problem if you work closely with the cultural needs.

Senator DECONCINI. Thank you, I have no further questions. Good program, obviously.

Senator BINGAMAN. Let me just ask any of you, Sally, maybe you're the right person because you're familiar with what we're doing here in New Mexico, to what extent are we pursuing something like this that Cheryl has described, in our high schools or elementary schools? Do we have one of these chemical awareness programs or something similar going on in various places?

Ms. DAVIS. There's a variety of programs across the State, and they vary. I know that Laguna Elementary School and a number of other BIA schools have Project Charlie, which is aimed at drug prevention and has been evaluated in other areas as being very successful.

We have a program now that we will be—we have just started May 1, as I said, to look at absenteeism as a way of identifying students at risk, because absenteeism is generally not related to a physical health problem. It is generally related to a psychosocial problem or to alcohol—or substance abuse, whether that is the problem of the family or an individual.

In addition to that, we have a project that will start in July funded by the State, the human services division and behavioral health division, and that is to implement a program in Bernalillo, Grants, Espanola, and again Laguna-Acoma.

And that intervention program is a program that has been tried in Utah and was very successful with Indian students, which uses peer counseling, peer education, and self-control technique, which has been shown to be very, very successful with other populations, has been tried at least in one site with Indian populations.

We will try to replicate that with our populations and see if it's successful. So yes, there are some things going on, they're very new. There's just not that much data on how effective it is.

Our approach is to very, very closely evaluate these kind of things, and since our programs are real community-based with a lot of community input, they are adapted for the local community, but are taken from some theoretical base that's been tried somewhere else.

Senator BINGAMAN. It sounds as though the program that Cheryl describes, she is the initiator of it, and it came out of the school system rather than out of the health care providing part of our society. Is it your thought that that's—maybe I ought to ask Cheryl that question. Is that the natural way to get to get this kind of a program going? I mean, is this the kind of thing that the schools themselves have to do? They can't wait or expect the Indian Health Service or the—whatever the alternative is if it's not involved with Indian people, but is it the schools that have to take the initiative on this instead of the health providing elements in our society?

Ms. WATKINS. I have found—this is what I have experienced in working, is that the schools decide to take responsibility for it. We can't teach kids when they're in that kind of emotional pain and they're under the influence. And the schools are taking ownership, but the schools can't do it alone. It is a partnership with the community. And the agencies, we need to refer out to them, and the agencies work very closely with us. We have 20 professionals from the agencies that come in and run groups with us and that do training.

But it's our programs. We take ownership, but we can't do it alone, and it is a partnership. And what is happening, you find if you can get the key decisionmakers, key board members, key superintendents, they will start buying into it and own it, and then we reach out to the community.

Senator BINGAMAN. Yes, Sally?

Ms. DAVIS. I'd like to make one more comment on that. People everywhere are really concerned. And the approach that seems to show the most promise across the country is a macro approach, where you involve every single person in the community. The churches, the schools, the health care providers, agencies, parents, grandparents, PTA's, all of those different groups have to have a plan of their own.

It all fits together. Somebody has to be the coordinator, whether it's the school, the community or the IHS or the university. Somebody has to orchestrate all of those parts, but everyone has to be involved.

Senator BINGAMAN. OK, that was excellent testimony, thank you.

Senator DECONCINI. It was.

Senator BINGAMAN. Thank you all very much. We've got two additional panels. Did you want to start another one, or do you want to leave?

Senator DECONCINI. No; I have to leave.

Senator BINGAMAN. OK, that's fine.

[Discussion off the record.]

Senator BINGAMAN. Senator DeConcini has to catch a plane back to Phoenix. We have two more panels, and we'll go right ahead with those at this time. I want to again thank Senator DeConcini for doing this, and for interesting the Select Committee on Indian Affairs in the Senate in holding this hearing. I think it's a major contribution.

Our next panel will be on health education, and William Blair with the State department of education, and Charles Johnson, who's with the Bureau of Indian Affairs, are the two witnesses.

Thank you both for being here. Why don't we take you in the order that I named you there? Bill, why don't you go ahead first, and then we'll hear from Charles?

Mr. BLAIR. Thank you very much. Let me get my pile oriented here, just a minute——

Senator BINGAMAN. OK, take your time there.

STATEMENT OF WILLIAM OWEN BLAIR, PH.D., SPECIALIST, HEALTH AND PHYSICAL EDUCATION, STATE DEPARTMENT OF EDUCATION, SANTA FE, NM

Mr. BLAIR. Senator Bingaman and guests, it's our pleasure, meaning the department of education, to be here today. We appreciate the opportunity to be here at this hearing and provide some testimony really in support of S. 400, the Indian Health Promotion and Disease Prevention Act of 1985.

We're interested in this particular bill for a number of reasons. One is that the bill encompasses health education the way we in the State of New Mexico at the department of education see health education. This is from the comprehensive approach.

We feel that we need to deal with all aspects of health education and your bill is suggesting, and this is the way that programs and things operate in the public schools in the State of New Mexico.

There is a mandate in New Mexico for health education, K-12. This is outlined in a book that we call "Educational Standards for New Mexico Schools." It includes in this all of the essential program requirements, rules, regulations, if you will, that all schools have to follow in the delivery of all programs.

It is, if you will, a State framework, and through local autonomy then school districts are allowed to fill in the blanks, if you will, as they wish, as long as they are in compliance with the framework that we call educational standards for New Mexico schools.

This means that in New Mexico all schools, K-12, are required to have health education programs being delivered in the schools.

I think you'll find that the teachers in the schools are trained in planning the programs. I think you'll find the teachers are trained in delivery of the program. I think that you would find one of the weaknesses of the curriculum process and in the program delivery in health education, at least, would be in the section called evaluation.

We organize well, we teach well, but we're not at this point really able to tell you and give you a good evaluation district by district of what's going on in the schools of New Mexico in terms of health education.

In terms at least from an evaluation standpoint of what the students know. We know what's been taught, we know what's been planned. We really don't know and have a good handle yet on what the students actually know themselves.

At the present time, there is no graduation requirement health education, even though there is a K-12 program requirement.

To assist teachers and school districts in the development of Program K-12, and in New Mexico we do take a district pholosophy, and that's why I continue to say K-12, we have developed a set of student competencies in health education. Competencies that should be mastered by all students in New Mexico, by grade level 3, by grade level 5, grade level 8 and by school exit or graduation.

And the content areas of health education that we require to be taught almost mirror the promotion and prevention objectives in the bill that we're discussing today. And so we think that's all in line and in order.

In my prepared statement, I provide you and the committee and the audience with a large amount of statistics which deal with the 22 districts in New Mexico that we consider native American school districts.

There are 88 school districts completely in New Mexico. There are 22 that we consider native American districts who have some sort of an Indian population in them.

And the data that I provide for you in the testimony is about the 22 school districts in New Mexico that are those that we consider the native Americans.

Let me just quickly go through what the content of the figures is about, or the subject that the figures are about. I think with additional time and reflection, there's a good bit of knowledge in there, but at least let me mention the topics that we try to cover in the statistical part.

We list the number of secondary health education teachers that are currently assigned to teach health education in the 22 school districts in New Mexico that have native American students.

We have some test results from the New Mexico high school proficiency exam, which does have a health education component on it. This is given to students at the tenth, eleventh and twelfth grades in the schools in New Mexico.

And you can note from there that the native American students are—have improved in their test scores in this particular test, but that they are below other ethnic groups.

I show you another figure, the number of school nurses assigned in the school districts in the 22 that we're talking about in New Mexico.

I provide for you a figure with the total number of students in each of the 22 school districts, along with the percentage of native American students in those school districts.

There's another figure which shows the percentage of native American teachers who are teaching in the native American school districts.

Another figure deals with the mobility rate of all students in the native American school districts. This has a real big impact on the delivery of programs.

There is some transportation information available in terms of the number of pupils that are transported in these districts, the number of buses that are in use, the annual live number of miles that school buses travel to get the kids to school.

There's a figure on State-funded and federally-funded bilingual programs in the native American school districts. There is a count of special education students of all types in the native American school districts in New Mexico.

And there's a large section on child nutrition information showing the number of meals that are served in lunch programs and breakfast programs, and the average daily participation of all students in these programs.

The intent behind all this information is to obviously bring out that it's not just the instructional program that has a bearing or an effect on what goes on in the schools with the kids.

If you bring a kid to school and he's hungry or if they can't hear or they can't see very well, if their complete needs are not taken care of, then no matter how good the instruction is, they just won't learn as well as someone who has all of these health needs taken care of.

Back into the testimony itself, and I'll just hit a couple of more highlights if I can, we do have a certification program for secondary health educators who teach health as a separate subject in the secondary schools.

I outline briefly what school nurses are to do in the school districts. I list the five institutions in New Mexico who are able to provide programs of certification and endorsement for teachers of health.

There's a section on instructional materials in the schools. There's a section on interagency cooperation, and then there's a listing of current and on-going health promotion and disease prevention activities that the department of education has been involved in recently.

Just a couple of other quick comments. The Surgeon General's goals and objectives have been mentioned a number of times today. I also would like to mention that through the State Department of Health and Environment, that there is a State health plan, and they have 13 health priorities that we in the State of New Mexico are supposed to be attempting to meet also.

The first priority in the State health plan is to decrease if possible violent deaths. This is accidents, suicides, homicides and those kinds of things. And so not only at the national level, but at the State level there is a concern for this effort.

I think that in general the New Mexico Department of Education and the Department of Health and Environment in particular do work well together promoting school programs and activities in the districts in New Mexico.

I also want to mention that the Governor's Office on Children and Youth has an on-going program which brings together their advisory committee along with representatives from each of the State agencies involved in children.

And so that as an on-going basis, if you will, the State agencies and the advisory committee are getting together dealing with issues of children and youth in New Mexico. And a good majority of the time, they're talking about health issues and issues related to health.

At this point, that'll end my testimony, and I'll be happy to field some questions later on.

[Mr. Blair's prepared statement follows. Testimony resumes on p. 270.]

STATE OF NEW MEXICO
DEPARTMENT OF EDUCATION - EDUCATION BUILDING
SANTA FE, NEW MEXICO 87501-2786

MAY 1985

LEONARD J. DE LAYO
SUPERINTENDENT OF PUBLIC INSTRUCTION

Prepared For: United States Senate
Select Committee on Indian Affairs
Mark Andrews, Chairman

Prepared By: William Owen Blair, PhD WOB
Specialist
Health Education and Physical Education

Subject: Report Concerning The Indian Health Promotion and Disease Prevention Act of 1985

I. State Mandate for Health Education

Educational Standards for New Mexico Schools, July 1984 states that each student's instructional program, K-12, shall include but not necessarily be limited to . . . . comprehensive health education including substance abuse education . . . .

Each district shall have a written curriculum, which is congruent with the delivered curriculum, which shall:

1. be based on an assessment of instructional and program needs;
2. specify student competencies expected at identified points during the program;
3. define the sequential progression of competencies to be attained; and
4. provide for the evaluation of student performance both during and upon completion of the program.

Currently, there is no graduation requirement of students for health education.

During the 1983-1984 school year, a statewide committee of health education professionals developed a set of grade level and exit/graduation competencies for students for health education.

Competencies to be attained by students by grade level 3, 5, 8 and school exit level were written for the following areas:

Personal Health Promotion
Mental/Emotional/Social Health
Family Life Education
Substance Use/Misuse/Abuse
Injury Control and Emergency Care
Environmental Health
Consumer Health
Nutrition
Human Growth and Development
Community Health
Disease Prevention

II. Method of Teaching Health Education

Districts may choose to teach health education as a separate subject or may choose to integrate health education into the school curriculum.

At the elementary level, health education is almost always taught by the self-contained classroom teacher. At the secondary level, some districts choose to teach health education as a separate subject while others choose to integrate the program into other required programs.

Figure 1 indicates the number of Secondary Teachers assigned to teach health education as a separate subject in the Native American School Districts in New Mexico for the year 1984-1985. Eight public school districts are teaching health education as a separate subject while 14 are integrating health education into the school curriculum.

When integrated, health education content is typically found in courses of Physical Education and Science. Depending upon the school district, health education content could be found in any of the other required program areas (Fine Arts, Computer Literacy, Language Arts, Mathematics, Practical Arts, Social Studies and Vocational Education.

III. Certification of Secondary Health Educators

A revised 24 hour endorsement, making a teacher eligible for an assignment in Secondary Health Education, grades 7-12, became effective on July 1, 1984.

A course in 6 specific areas are required including a course in human sexuality and a course in substance use.

Individuals endorsed in Secondary Health Education, prior to July 1, 1984 are not required to comply with this revised regulation.

IV. New Mexico Basic Skills Plan

The objective test portion of this plan tests knowledge in several areas including "Mental and Physical Health." The four major objectives in this area are:

1. The individual should know where, when, and why to seek medical help.
2. The individual should know what personal habits promote good health.
3. The individual should know how to apply principles of health to planning and raising a family.
4. The individual should know how to deal with potential hazards and accidents.

The spring 1985 results of this examination appear as Figures 2, 3, 4, 5 and 6.

V. School Health Services

Each school district shall:

1. provide health services in each school unit,
2. provide health services designed to improve the student's mental and physical health by coordinating with other school staff and community agencies,
3. design and staff the program with trained health personnel to meet assessed needs; and
4. shall have a certified school nurse available to direct the health services program.

Specific health services, contacts and tasks are outlined in the School Health Manual.

Figure 7 shows the number of School Nurses assigned in the Native American School Districts in New Mexico.

VI. Teacher Preparation

Five New Mexico Institutions of Higher Learning have approved programs for certification/endorsement in the teaching of health. Below is a

The Number of Teachers Assigned to Teach Health Education in the Native American School Districts In New Mexico 1984-1985

Districts	Health Education Teachers
Albuquerque	52
Aztec	0
Bernalillo	0
Bloomfield	0
Central	0
Cuba	2
Dulce	0
Espanola	0
Farmington	0
Gallup	2
Grants	3
Jemez Mountain	0
Jemez Springs	0
Los Lunas	3
Magdalena	0
Penasco	0
Pojoaque	0
Ruidoso	0
Santa Fe	0
Taos	1
Tularosa	1
Zuni	1

The Number of School Nurses Assigned in the Native American School Districts in New Mexico
1984-1985

Districts	School Nurses	LPNs	MDs
Albuquerque	84		
Aztec	1		
Bernalillo	4		
Bloomfield	2		
Central	6		
Cuba	1	1	
Dulce	1		
Espanola	5		
Farmington	7		
Gallup	6		
Grants	4		
Jemez Mountain	2		
Jemez Springs	1		
Los Lunas	3		
Magdalena	0	1	1
Penasco	1		
Pojoaque	2		
Ruidoso	1		
Santa Fe	11		
Taos	3		
Tularosa	1		
Zuni	1		

New Mexico High School
Proficiency Examination

ADMINISTRATIVE SUMMARY BY CONTENT AREA

	ALL STUDENTS				ANGLO		HISPANIC		NATIVE AMERICAN		BLACK		OTHER	
	MEAN SCALE SCORE	MEDIAN SCALE SCORE	MEAN % CORRECT	LOCAL % ILE	LOCAL % ILE	MEDIAN SCALE SCORE	LOCAL % ILE	MEDIAN SCALE SCORE	LOCAL % ILE	MEDIAN SCALE SCORE	LOCAL % ILE	MEDIAN SCALE SCORE	LOCAL % ILE	MEDIAN SCALE SCORE
COMMUNITY RESOURCES														
GRADE 10	580.8	586.5	81.1	51	67	607.6	37	573.2	26	551.7	26	560.8	51	583.0
GRADE 11	569.6	565.3	74.2	37	67	604.0	18	549.2	12	534.6	12	536.0	37	568.7
GRADE 12	576.3	573.7	75.8	37	67	613.4	26	553.1	12	530.7	37	568.2	37	566.2
TOTAL	584.9	584.4	80.0	51	67	607.8	37	571.6	18	546.1	24	557.8	51	581.5
CONSUMER ECONOMICS														
GRADE 10	581.8	577.3	81.1	52	68	598.3	36	568.2	25	548.7	36	552.3	52	573.0
GRADE 11	565.9	561.0	75.8	36	68	597.8	25	548.0	16	533.8	16	540.4	36	561.4
GRADE 12	575.4	573.2	77.9	52	68	615.2	25	550.1	16	530.6	52	572.2	62	570.8
TOTAL	578.7	575.8	80.5	52	68	596.2	36	565.7	28	543.9	36	560.1	52	572.0
GOVERNMENT AND LAW														
GRADE 10	584.4	585.2	71.5	53	65	606.3	42	571.6	24	551.9	32	566.1	42	581.8
GRADE 11	569.7	563.8	65.0	32	65	603.8	24	550.8	17	533.5	17	536.5	32	564.8
GRADE 12	581.4	577.8	68.8	42	76	621.2	24	551.8	11	531.2	53	587.3	42	572.0
TOTAL	586.1	582.9	71.0	53	65	607.0	42	568.5	24	545.9	32	561.1	42	578.6
MENTAL AND PHYSICAL HEALTH														
GRADE 10	578.4	576.0	81.7	48	68	591.9	46	567.3	20	545.4	45	566.8	48	573.1
GRADE 11	561.1	559.3	75.6	32	68	591.8	20	544.8	13	530.3	20	539.1	32	556.3
GRADE 12	567.3	564.8	77.2	32	68	603.4	20	545.1	13	528.8	32	557.0	32	562.6
TOTAL	575.9	573.6	80.6	48	68	593.4	32	564.8	30	540.2	32	562.6	43	571.2
OCCUPATIONAL KNOWLEDGE														
GRADE 10	584.7	583.8	80.5	50	66	604.2	37	573.1	21	547.2	37	588.7	50	578.4
GRADE 11	566.4	563.7	74.0	37	66	604.0	31	548.5	16	531.4	21	540.2	28	561.2
GRADE 12	576.4	578.5	76.5	37	66	620.8	28	549.2	16	533.4	50	576.0	37	568.0
TOTAL	582.3	581.8	78.5	50	66	604.6	37	569.8	21	542.0	37	566.7	50	576.8

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New Mexico High School Proficiency Examination

ADMINISTRATIVE SUMMARY BY TOTAL CONTENT AREA

PASSING SCORE 523

									REVIEW 1984		REVIEW 1983	
	NO. PASS	NO. FAIL	% PASS	% FAIL	MEAN SCALE SCORE	MEDIAN SCALE SCORE	MEAN % CORRECT	LOCAL % ILE	MEAN SCALE SCORE	% PASS	MEAN SCALE SCORE	% PASS
ALL STUDENTS												
GRADE 10	16510	1321	92.6	7.4	585.0	585.6	79.1	52	577.2	91.1	575.6	91.2
GRADE 11	1811	405	81.7	18.3	566.9	563.1	72.8	30	560.4	79.6	559.3	78.7
GRADE 12	995	225	81.6	18.4	576.3	578.2	75.1	41	568.1	79.8	565.9	82.9
TOTAL	19316	1951	90.8	9.2	582.6	584.0	78.2	48	574.8	88.7	573.0	89.2
NUMBER OF NON-ATTEMPTS	6											
ANGLO STUDENTS												
GRADE 10	6848	112	98.4	1.6	605.6	604.8	84.9	67	596.8	97.8	596.7	98.1
GRADE 11	669	21	97.0	3.0	603.8	604.5	84.2	67	598.9	95.2	595.1	95.8
GRADE 12	423	4	99.1	0.9	617.5	619.0	87.2	78	603.5	97.0	598.7	97.5
TOTAL	8040	138	98.3	1.7	606.1	605.3	85.0	67	597.4	97.7	595.8	97.8
HISPANIC STUDENTS												
GRADE 10	5942	569	91.4	8.6	573.5	572.9	76.1	38	566.7	89.3	566.6	90.7
GRADE 11	613	172	78.1	21.9	551.6	548.5	68.8	30	550.4	73.4	548.1	77.2
GRADE 12	247	78	76.0	24.0	557.0	550.2	69.8	20	552.1	72.8	555.3	82.8
TOTAL	6802	809	89.4	10.6	570.5	570.5	75.1	35	564.3	86.9	564.0	88.8
NATIVE AMERICAN STUDENTS												
GRADE 10	1144	321	78.1	21.9	551.1	551.1	68.6	22	548.6	75.8	547.6	77.9
GRADE 11	237	116	67.1	32.9	536.4	532.5	63.2	11	532.8	58.2	534.1	63.6
GRADE 12	155	103	60.1	39.9	537.1	538.2	63.1	10	535.2	60.8	536.1	68.3
TOTAL	1536	540	74.0	26.0	546.8	543.7	67.0	17	544.0	70.7	543.7	73.7
BLACK												
GRADE 10	280	46	85.9	14.1	560.1	567.9	74.6	33	557.8	86.7	556.5	81.6
GRADE 11	33	16	67.3	32.7	539.4	534.9	64.3	12	538.9	69.3	549.6	73.7
GRADE 12	25	4	86.2	13.8	574.7	573.0	75.2	38	545.9	75.8	541.8	65.4
TOTAL	338	66	83.7	16.3	565.9	563.4	72.9	30	553.8	83.0	553.0	78.5
OTHER												
GRADE 10	2196	282	88.6	11.4	578.4	580.5	77.1	45	569.5	85.5	560.8	80.8
GRADE 11	259	80	76.4	23.6	563.3	564.2	71.3	30	545.5	64.4	543.0	64.8
GRADE 12	145	36	80.1	19.9	569.6	567.7	73.4	33	556.8	78.0	553.5	72.1
TOTAL	2600	398	86.7	13.3	576.6	579.0	76.1	46	565.8	83.3	558.3	78.4
MALE												
GRADE 10	8316	759	91.6	8.4	584.7	585.9	78.9	52	575.0	89.7	573.8	89.5
GRADE 11	929	221	80.8	19.2	566.1	559.3	72.5	28	558.4	74.3	557.1	76.6
GRADE 12	509	118	81.2	18.8	573.9	572.8	74.5	38	566.1	79.1	564.3	79.8
TOTAL	9754	1098	89.9	10.1	582.1	584.0	77.9	48	572.5	87.2	571.1	87.3
FEMALE												
GRADE 10	8194	562	93.6	6.4	586.2	585.4	79.4	48	579.5	92.8	577.3	93.0
GRADE 11	882	184	82.7	17.3	567.9	567.4	73.4	33	562.9	77.2	561.7	81.2
GRADE 12	486	107	82.0	18.0	578.8	583.5	75.8	48	570.3	80.5	567.4	86.0
TOTAL	9562	853	91.8	8.2	583.1	584.1	78.6	48	577.3	90.7	574.9	91.2

The Student Mobility Rate in the Native American School Districts in New Mexico
1983-1984

Districts	Student Mobility Rate*
Albuquerque	29.4
Aztec	32.0
Bernalillo	15.6
Bloomfield	28.1
Central	26.3
Cuba	26.1
Dulce	26.7
Espanola	22.3
Farmington	33.6
Gallup	28.5
Grants	29.2
Jemez Mountain	25.0
Jemez Springs	17.0
Los Lunas	23.1
Magdalena	20.5
Penasco	14.1
Pojoaque	18.5
Ruidoso	39.8
Santa Fe	24.1
Taos	17.1
Tularosa	23.2
Zuni	25.2
State Average	28.5

* - The value is the % of the student body moving into or out of the school district each year.

list of these institutions along with the total number of staff assigned to teach health education courses:

Institution	Faculty
Eastern NM University	4
NM Highlands University	6
NM State University	4
The University of NM	14
Western NM University	1

VII. Instructional Materials in the Schools

There is an approved instructional materials list for health education materials. The materials on this list have been reviewed and selected through a specific process of committee work and public hearings.

School districts may select/purchase/use any materials of their choice to assist with an instructional program.

Upon request, the State Department of Education will review materials not on the approved list and will inform districts as to the availability and merits of these materials. Specific programs and products are not endorsed for use in school districts by the State Department of Education.

VIII. Interagency Cooperation

Continuing activities are occurring with:

Department of Corrections
Department of Health and Environment
Department of Human Services
Department of Transportation
Governor's Office of Children and Youth

IX. Current/Ongoing Health Promotion and Disease Prevention Activities

1. A member of the State Department of Education staff traveled with a group from New Mexico led by Senator Bingaman to attend a workshop put on by the Stanford Center for Research in Disease Prevention Program at Stanford University.

2. A member of the State Department of Education staff attended a Conference of State, County and City School Superintendents to Improve Health Promotion Programs in the Nation's Schools in Bethesda, Maryland sponsored by the Cancer Control Science Program at the National Cancer Institute and the American Health Foundation.

3. A member of the State Department of Education staff is working with Senator Bingaman and HEALTH NET - NEW MEXICO whose mission is to improve the health of the people of New Mexico and by so doing, to improve the quality of life in New Mexico, to increase the productivity of New Mexico citizens and to reduce the need for expensive medical treatment for New Mexicans.

4. A member of the State Department of Education staff is leading a team of nine health professionals and will attend a Health Promotion Workshop in Seaside, Oregon this month. This team will return to New Mexico and organize a health promotion conference in New Mexico during the summer of 1986.

5. The State Department of Education is developing a non-smoking policy for the agency in order to comply with the Clean Indoor Air Act of 1985 passed by the New Mexico Legislature and signed into law by Governor Toney Anaya.

6. The State Department of Education assisted the Department of Transportation and Luz-Kline Media in their recently completed Kids Against Drunk Driving Contest.

7. The State Department of Education wrote a letter of support for a Native American Adolescent Injury Prevention Project submitted by the Injury Control and Adolescent Health Programs of the Department of Health and Environment.

8. The State Department of Education participates regularly with the Governor's Office of Children and Youth and their activities.

9. The State Department of Education assisted the Magdalena Municipal Schools and the Magdalena BIA Dormitory with a recent proposal regarding the School Team Cluster Approach for Substance Abuse.

10. The State Department of Education maintains an open relationship with the Community Health Education Program of the Albuquerque Area Indian Health Service.

11. During the recent New Mexico Legislature, the State Department of Education met with a group of Native American legislators to discuss curriculum/program including health education.

12. The State Department of Education has met recently with the Administrators and Department Heads at Santa Fe Indian School to discuss curriculum/program.

The Total Full-Time Equivalent Staff in the Native American School Districts in New Mexico and the Percentage of Native American Teaching Staff
1983-1984

Districts	Total FTE Staff*	% of Native Americans**
Albuquerque	5086	0.4
Aztec	160	0.0
Bernalillo	213	6.3
Bloomfield	180	1.8
Central	342	19.2
Cuba	59	8.3
Dulce	48	2.7
Espanola	362	2.6
Farmington	482	1.6
Gallup	675	7.1
Grants	281	4.2
Jemez Mountain	46	2.7
Jemez Springs	36	3.4
Los Lunas	226	0.5
Magdalena	36	0.0
Penasco	49	0.0
Pojoaque	90	3.8
Ruidoso	99	0.0
Santa Fe	732	0.6
Taos	197	0.6
Tularosa	93	3.7
Zuni	107	20.6

* = This value represents the total number of all full-time equivalent certified staff employed by the district.

** = This value represents the Native American make-up of the teaching staff.

The Number of Students In the Native American School Districts In New Mexico and the Percentage of Native American Students 1983-1984

Districts	Total N of Students	% of Native Americans
Albuquerque	72,510	3
Aztec	2,583	17
Bernalillo	2,920	48
Bloomfield	3,109	32
Central	5,593	84
Cuba	620	56
Dulce	609	87
Espanola	5,190	2
Farmington	7,910	11
Gallup	11,069	66
Grants	4,498	30
Jemez Mountain	554	2
Jemez Springs	459	60
Los Lunas	3,844	9
Magdalena	446	56
Penasco	791	2
Pojoaque	1,371	14
Ruidoso	1,694	8
Santa Fe	10,716	2
Taos	2,976	5
Tularosa	1,281	30
Zuni	1,516	99

Senator **Bingaman**. All right, I'll have a few questions, but first let's go ahead and hear from Charles Johnson, who is with the BIA in Fort Defiance. Go right ahead.

STATEMENT OF CHARLES JOHNSON, FT. DEFIANCE AGENCY, BUREAU OF INDIAN AFFAIRS, FT. DEFIANCE, AZ

Mr. **Johnson**. Good afternoon, Senator Bingaman. My name is Charles Johnson. I am the agency superintendent for education at Fort Defiance. I'm happy to have this opportunity to discuss health-related instruction in our schools.

The Department of the Interior defers to the Department of Health and Human Services on S. 400. The BIA works closely with IHS in providing health services to our children. For example, the IHS provides immunization services for our children, maintains in some cases nursing stations, either part- or full-time at most of our schools.

Where these nursing stations are not available, then our staff at the schools transports students that are identified as needing these services to IHS facilities.

We feel that the teachers have the best opportunity to recognize the health-related problems in our students, and they do frequently refer the students to IHS for treatment.

Each school is required to provide health education as a part of its curriculum, and as a part of this, it must include alcohol and drug prevention. Since the development of such programs is a local decision, they vary significantly across the country.

Frequently, programs are developed in coordination with the local IHS representative and the tribe, and they may be as simple as including a unit on the subject as a part of the curriculum, or it may involve the provision of speakers, presenters, and trainers from tribe as well as IHS.

Unfortunately, our schools can only provide material and discussion on the subject as a part of our curriculum.

Our schools sometimes become involved in referral of students to tribal courts or the IHS if the students arrive at school under the influence of intoxicants, whether it be drugs or alcohol.

The problem must be addressed in a more comprehensive way, though, through coordinated delivery of available community service programs.

That concludes my statement, and I will be happy to answer questions.

[Mr. Johnson's prepared statement follows:]

PREPARED STATEMENT OF MR. CHARLES JOHNSON, AGENCY SUPERINTENDENT FOR EDUCATION AT THE FORT DEFIANCE AGENCY, BUREAU OF INDIAN AFFAIRS, DEPARTMENT OF THE INTERIOR

Good Morning. My name is Charles Johnson, I am the Agency Superintendent for Education at the Ft. Defiance Agency. I am happy to have this opportunity to discuss health related instruction in our schools. The Department of the Interior defers to the Department of Health and Human Services on S. 400.

The Bureau of Indian Affairs (BIA) works closely with the Indian Health Service (IHS) in providing health services to our Indian children. For example, the IHS provides immunizations for childhood diseases and maintains a nursing station either part or full-time at most Bureau schools. Where nursing facilities are not available, the school personnel provide transportation for the student to the nearest IHS facility. Naturally, the teachers have the best opportunity to recognize health related problems in our students and frequently refer students either formally or informally to IHS for medical services ranging from eye examination to psychological testing. Referral procedures are worked out with the appropriate IHS facility.

Each school is required to provide health education as part of its curriculum and must include alcohol and drug prevention as part of that curriculum. Since the development of the program is a local school decision, they, of course, vary significantly. Frequently, programs are developed in coordination with the local IHS representative and the tribe and may be as simple as including a unit on the subject as part of the health curriculum, or as extensive as having speakers and special materials in each classroom throughout the year. Unfortunately, our schools can only provide material and discussion on the subject as part of our curriculum. Our schools may also become involved in referral to the IHS or the tribal court if a student attends school while intoxicated or under the influence of drugs. The problem must be addressed in a more comprehensive way though the coordinated delivery of available community service programs.

This concludes my prepared statement and I will be happy to answer any questions the Committee mav have.

Senator BINGAMAN. Let me start and ask Bill a few questions about the public school system here in the State. You heard the testimony that Cheryl Watkins gave us about the chemical abuse——

Mr. BLAIR. Yes sir, I did.

Mr. BINGAMAN [continuing]. Awareness, or the Chemical Abuse Prevention Program that she's working on in Phoenix.

What statistics or information do we have in New Mexico by school district or by school as to the need for such a program?

Mr. BLAIR. We don't have a clear set of New Mexico data on the incidence of alcohol-drug abuse, if you will, with school-age children.

The State epidemiologist in Santa Fe typically says that he feels based on his judgment and information, that's what happens nationwide, happens in New Mexico. And so I don't know the exact percentages of that, but I think the incidence in New Mexico schools in general probably—according to Dr. Harry Hull, mirrors the State—or mirrors the national statistics.

Senator BINGAMAN. So the same problems that she was describing as encountering in the school system in Phoenix is probably present in some of our own schools here in New Mexico?

Mr. BLAIR. Yes sir, I think that's a fair statement.

Senator BINGAMAN. Do we have any programs you're aware of that are as comprehensive as the Chemical Abuse Prevention Program she described, in place, operating right now?

Mr. BLAIR. A great number of school districts in New Mexico have taken on chemical-use abuse, if you will, as a major focus. There are a number of school districts who have similar programs to what she has described that are ongoing in the schools in New Mexico.

Some of these are through groups, parents in action, that sort of thing. The chemical people have a number of parent and community groups working throughout the State. A number of school districts have gone to other means to address this particular issue.

Several school districts in New Mexico have submitted proposals and have been funded for what is called a school team approach by the Center for Educational Development out of San Antonio, Texas, which is really a sort of an arm of the office of education, where they are training teachers on a school team approach off campus, and then those people come back on campus and provide the program an additional training, so that it becomes a real school and district program in New Mexico.

Senator Bingaman. Could you name, or maybe if you can't name right now, you could provide it to me, but what school district or school districts are doing the best job in this chemical-abuse prevention area, in your view?

Mr. Blair. At this point, I think that the most developed programs that I'm aware of, at least, in New Mexico, would probably be in Albuquerque, Los Alamos, and Santa Fe and maybe Espanola.

The office of children and youth last year asked each school district to submit model programs in substance use and abuse that they had in the public schools, and so I can provide you pretty much with a complete list at least from last year as to the programs by school district that are ongoing in New Mexico for students.

Senator Bingaman. I guess Arizona this last year adopted a State law which would essentially set up a school Chemical Abuse Prevention Program, providing funds for something along the lines that Cheryl described statewide for any school district.

In your view, would that be a good step for us to take in this State?

Mr. Blair. We took that step about 15 years ago, Senator. The typical growth in school health education is that first of all a State has to recognize that health education is a legitimate subject area. And before that happens—and this is nothing negative, this is the typical transition that has occurred from State to State to State. Typically, until the comprehensive approach is decided upon, States react to hot topics, if you will.

One year the hot topic may be chemical use. The next year it might be nutrition, maybe its teenage pregnancy the next year, and so ultimately the States—and New Mexico has done that since about 1974, come to grips with the fact that you can't deal with health issues one at a time. You have to deal with the whole issue, if you will, the whole child, and to do that, you really need to take a comprehensive health education approach, still allowing districts to focus, if you will, in a particular area of health education, but also mandating that they do cover and deal with all issues of health education.

Senator Bingaman. So you think that the type of—sort of focused, statewide effort, that was described or that Arizona evidently just got into is really not the solution, the solution is a more comprehensive commitment to health education, is that your——

Mr. Blair. Yes, sir.

Senator Bingaman [continuing]. Statement?

Mr. Blair. Yes, sir.

Senator Bingaman. And your testimony is essentially that we are doing this right now in our schools, that it's a requirement and that the schools are doing it, is that accurate?

Mr. Blair. Yes, sir. I think we could all do a better job, but I think that it is happening to some degree out there at the present time.

Senator Bingaman. I guess it's that to some degree that concerns me a little bit, because I pick up anedotally that it's not happening to a great degree a lot of places. That it's a requirement that is somewhat overlooked by school boards and is given a low priority in many school districts. Is that a fair statement?

Mr. **Blair**. That's a fair statement. I struggle with that every day. In New Mexico, as I mentioned, health education is a program requirement of all school districts, K-12.

We have eight other programs that are mandated to be taught, K-12, in the State of New Mexico. One of the great things, and yet one of the difficult things about local autonomy is that the school districts can decide how much emphasis to place in each of those required program areas.

And as the health advocate for the State department of education, I would have to say that health education is not always the highest priority in the instructional or support services programs.

Senator **Bingaman**. OK.

Mr. **Blair**. In my view.

Senator **Bingaman**. OK.

Mr. **Blair**. Now, one way to get across and I think to solve that, if you don't mind if I pursue that just a bit——

Senator **Bingaman**. Go right ahead.

Mr. **Blair**. We have eight or nine programs that are required, all of those programs have a graduation requirement for students to leave the high school with the exception of health education and computer literacy. If the State board of education was to increase graduation requirements for the State of New Mexico and require health education either as a one-semester or a 1-year course or something for all students to pass, then I think that this would begin to get the attention of some of the school administrators who may have held it as a little bit of a lower priority in their scale at this point, even though they feel they're addressing it to some point.

Again, that always kind of gets back to the evaluation, too, because we're not quite at this point able to evaluate, and the school people really are not able to evaluate the effectiveness of the health education program that they have, and so they can just say, well, we think we have enough, but we really don't know.

Senator **Bingaman**. Of the 22 Indian school districts that you've referred to in your testimony, is there a—is there any effort that you know of by those school districts to get together and compare what they're doing to handle the health problems that may be peculiar to the Indian student?

Mr. **Blair**. I've been working for the State department of education for 4 years. To my knowledge, the 22 school districts in New Mexico have never gotten together to talk strictly about the health issues, education services, et cetera, of the native American students in their districts.

I think that would be an excellent suggestion. I think we need to do that, because to my knowledge, we have not done that in the past.

Another problem that we face, obviously trying to keep track of 88 school districts and programs K-12, and in my case with one person doing that, it begins to be a bit of a load, we have not really either had an excessive interchange, we've had some, with some of the Indian educators, either in pueblos or in some of the other tribes, that sort of thing.

We need to do more of that, and at this point we have not done that. We would be happy to meet with the Indian Health Service people, the BIA Department of Education people. We have met with the Navajo Nation educators and a few others, as mentioned in my testimony, but in terms of a real high level meeting, either with the—strictly the department of education, State of New Mexico, with the 22 districts or with some of the Federal agencies with education, we really haven't done that, to my knowledge, to much of an extent.

Senator BINGAMAN. OK, let me ask—just a second. Mr. Johnson, let me ask you, if I could, just a couple of questions as well. Your testimony is similar to Dr. Blair's, in that you're saying, as I understand it, that there is a requirement that the BIA schools teach health education, and that is happening to some extent?

Mr. JOHNSON. Yes, sir.

Senator BINGAMAN. Is the same problem present in the BIA schools that I tried to describe in the public schools, that is, that in many cases it's not being given any priority and it's not being done well?

Mr. JOHNSON. Well, as I stated, Senator Bingaman, in my prepared testimony, the decision concerning health education and drug alcohol abuse programs is to some extent a local decision, and in some areas I think it would be fair to say that more emphasis is given than in others.

Senator BINGAMAN. Why is it a local decision. I mean, I can understand in the case of the State that you've got all these locally elected boards of education. In the case of the BIA, it would strike me that you would have an ability to somewhat mandate the curriculum in the BIA schools to a greater extent than maybe the State can get away with.

Mr. JOHNSON. Senator, with the advent of Public Law 95-56, the law on Indian education provided the local boards with more authority in the area of policymaking and in the area of curriculum, and that is why I'm referring to that as a local——

Senator BINGAMAN. Before that law went into effect, was there a better job being done of health education in BIA schools than there is today, is that what you're suggesting?

Mr. JOHNSON. No, sir; I'm not suggesting that. I'm just saying that the programs do vary because of the local decision on where the emphasis is going to be. All schools, however, do have health programs. All schools do have an Alcohol and Drug Abuse Program. The extent is somewhat limited. I'm not saying that the responsibility lies with the school boards. Some of it is the fact that there are curriculum development problems, that is, in the development of curriculum suitable for the grade levels we have.

Senator BINGAMAN. You don't have the teaching materials that you need in order to pursue the course, is that what you're saying?

Mr. JOHNSON. At this point, we don't have a single curriculum across the schools, that's correct.

Senator BINGAMAN. What would the Congress have to do, if the Congress were to decide—and I'm not suggesting they would, because they're 535 there in Congress, but if Congress were to decide that because of the health problems of the Indian people in this country, that a particular priority needed to be given to health education in BIA schools, and that we would no longer want to leave this to local discretion, and we basically want to ensure that a certain minimal amount of instruction is given in BIA schools, what would we have to do to get that implemented?

Mr. JOHNSON. I don't think I can answer that, sir.

Mr. BLAIR. Senator, excuse me——

Senator BINGAMAN. Yes; go right ahead.

Mr. BLAIR [continuing]. Something that we do in the State Department of Education which might be applicable to the problem that you just brought up is this: In many cases, the teachers who are teaching in the schools in New Mexico, at least, are not trained in health education, particularly at the elementary school level. All of the teachers who are teaching elementary school have gone through teacher education programs at a number of universities.

The great majority of universities in New Mexico, and I think throughout the United States, do not require elementary education teachers to take a methods course or a materials course, if you will, in how to teach health education in the elementary schools.

And so all these people have been trained and are out in the field teaching at the elementary level, and a great number do not have a real background in how to teach health education.

They know how to teach, and they know how to teach most of what other people consider the core courses, like language arts, math, science and that sort of thing, but they're really not trained to teach health education.

Now, there is a philosophical judgment, I think, that can be made to assist teachers with lack of training, and I think a number of public school teachers have that lack of training.

Currently, there are a number of programs of health education that have been developed by local educational agencies, educational research agencies and various health foundations that provide health instruction, K-12, in what we might call a canned program, and again that's not in the negative sense.

Many of these programs are K-12, some are K-6, some jump in for only grades four, five or six or something like that.

Very specifically, three come to mind. There is a program with the American Health Foundation out of New York City called Know your Body, which is a K-8 health education program.

The Center for Health Education developed and is implementing throughout the United States a school health education project, which is a K-8 health education program, which is a canned program, so in order for a district or a teacher to implement that program, they go through anywhere from a two, three days through a week-long training session.

And then they have a program of health education to implement into their school. Now, obviously a single health education program may not meet the needs of every school district, because each is a little bit different. But on the other hand, it's a real positive approach because the health needs of almost every child to some point are the same.

And obviously with that bit of training, then the teachers would be able to be creative and adapt what they have learned through this short program, if you will, be able to adapt it to then totally meet the needs of their district or their school, and it works.

And there is data to support those and other programs just like it.

Senator BINGAMAN. Let me just ask a sort of final question for any of you here. I think, Bill, you said that the No. 1 priority in the State health plan is to decrease the number of violent deaths?

Mr. BLAIR. Yes, sir.

Senator BINGAMAN. And the statistics we've heard today indicate that the highest concentration of violent deaths is in the Indian community in this State by far.

Mr. BLAIR. Um-huh.

Senator BINGAMAN. And the other evidence that we've heard we've heard is that the most effect can be had by concentrating on the youth within that sector.

Mr. BLAIR. Um-huh.

Senator BINGAMAN. In order to deal with it. If the No. 1 priority of the State health plan is to decrease the number of violent deaths, what are we doing to instruct Indian children in ways that would reduce the incidence of violent deaths in the Indian community down the road? Do we have a program that singled out this group for a special intensive effort in order to reach this—or deal with this No. 1 priority?

Mr. BLAIR. On a statewide basis, we do not have a program that is set up to exactly do that. Within the competencies of health education, the document I referred to a minute ago, there is a section on injury control and first aid, and that gets at safety, accident prevention, et cetera, et cetera, and that obviously should be a part of some of the other sections in there dealing with substance abuse and that sort of thing.

But except for the student competencies, the planned program approach, I'm not aware of a program that we have outlined to date which focuses on that most serious problem in the Indian districts in New Mexico.

Senator BINGAMAN. OK; let me ask Mr. Johnson. How many children do we have in the BIA schools in New Mexico, do you have an estimate?

Mr. JOHNSON. No sir, I don't have those figures. I can get them for you, and I would be happy to provide them.

Senator BINGAMAN. I'd appreciate if you could sort of break it down by grade. That would be very useful.

Mr. JOHNSON. Are you talking about BIA schools, or the entire Indian population? That's—there's two different segments here. I have—for example, in my agency, two schools in New Mexico, and other schools in Arizona. I can get you the BIA figures for New Mexico schools.

Senator **Bingaman**. That's really what I was looking for.

Mr. **Johnson**. I will provide those for you, sir.

Senator **Bingaman**. All right, thank you both very much. Appreciate your testimony.

Mr. **Blair**. Thank you.

[At Senator Bingaman's request for additional information, the following letter, dated September 30, 1985, was received from Ms. Nancy Garrett, Deputy Director, Office of Indian Education Programs:]

United States Department of the Interior
BUREAU OF INDIAN AFFAIRS
WASHINGTON, D.C. 20245

IN REPLY REFER TO:
Education - Code 501

SEP 30 1985

Honorable Dennis DeConcini
Select Committee on Indian Affairs
Room SH-838
Senate Hart Office Building
Washington, D. C. 20510

Dear Senator DeConcini:

Mr. Charles E. Johnson, Bureau of Indian Affairs Agency Superintendent for Education at Fort Defiance, represented the Department of the Interior in a public hearing which you chaired. During Mr. Johnson's testimony on Senate Bill 400, the Indian Health Promotion and Disease Prevention Act of 1985, Senator Jeff Bingaman requested, for the record, a breakdown by grade of the number of Indian children in BIA schools in New Mexico. The enclosed information on school year 1984-85 is provided for inclusion in the hearing record. Student enrollment data for the current school year is not available at this time.

If further information is required, you may contact my office on 343-2123.

Sincerely,

Deputy Director, Office of Indian
Education Programs

Enclosure

FY 1985 Student Count of Indians in BIA Schools in New Mexico

	Total Number of Students	Enrollment by Grades			
		K	1-3	4-8	9-12
Pine Hill Schools	383	36	97	142	108
Santa Fe Indian School	457	--	--	127	330
Sky City Community School	323	54	123	145	1
Isleta Elementary School	243	54	114	75	--
Jemez Day School	176	29	86	61	--
San Felipe Day School	295	35	131	129	--
Zia Day School	97	16	40	41	--
Laguna Elementary School	465	85	209	171	--
San Ildefonso Day School	31	9	17	5	--
San Juan Day School	85	17	37	31	--
Santa Clara Day School	100	26	36	38	--
Taos Day School	122	18	49	55	--
Tesuque Day School	29	2	14	13	--
Beclabito Day School	95	23	58	14	--
Cove Day School	83	14	33	36	--
Nenahnezad Boarding Schl	455	106	215	134	--
Sanostee Day School	88	42	46	--	--
Toadlena Boarding School	375	43	130	202	--
Shiprock Alternate High School	107	--	--	--	107
Navajo Mission Academy	216	--	--	--	216
Charles Renk Elementary	38	38	--	--	--
Baca Community School	81	45	36	--	--
Dibe Yazhi Habitiin Olta	175	33	68	74	--
Bread Springs Day School	92	25	67	--	--
Chi-Ch'il Tah Community	133	30	81	22	--
Jones Ranch Day School	54	14	34	6	--
Lake Valley Navajo School	118	12	39	67	--
Mariano Lake Community	161	37	98	26	--
Ojo Encino Day School	158	30	80	48	--
Pueblo Pintado Community	204	29	72	103	--
Standing Rock Community	56	22	34	--	--
Dlo'Ay Azhi Community	127	20	64	43	--
Na'Neelzhiin Ji' Olta'	312	50	116	146	--
Wingate Elementary School	572	--	168	404	--
Wingate High School	898	--	--	--	898
Crownpoint Community Schl	581	57	200	324	--
Dzilth-na-o-dith-hle Community School	359	28	112	219	--
To'Hajiilee-He	252	26	74	86	66
Alamo Navajo School	285	34	87	124	40
Chuska/Tohatchi Consolidated School	648	37	224	387	--
Crystal Boarding School	174	43	79	52	--
	9,703	1,219	3,168	3,550	1,766

In addition, the Bureau operates five (5) peripheral dormitories in New Mexico to house Indian children attending public schools.

	Total Number of Students	Enrollment by Grades			
		K	1-3	4-8	9-12
Jicarilla Dormitory	36		11	10	15
Aztec Dormitory	109				109
Shiprock Dormitory	76		2	7	67
Huerfano Dormitory	129		46	60	23
Magdalena Dormitory	148		13	39	96

Senator **Bingaman**. The final panel we're going to have is on Indian health boards and urban clinics, and we have five people here who are on the panel—oh, we have six—oh, just those three? OK, we just have three people. Francisca Hernandez, Ona Porter and Ken Reid are the three there, and then I gather we do have some additional witnesses who come after that panel, is that right? OK, so if you're still expecting to testify, you don't need to run off. We'll still give you a chance.

If you folks would go ahead and identify yourselves and tell us what we need to know today. We appreciate your being here very much.

STATEMENT OF FRANCISCA HERNANDEZ, EXECUTIVE DIRECTOR, AND ONA LARA PORTER, DIRECTOR, PLANNING AND COMMUNITY DEVELOPMENT, BOTH OF THE ALBUQUERQUE AREA INDIAN HEALTH BOARD, ALBUQUERQUE, NM

Ms. **Hernandez**. Thank you. We appreciate the opportunity to be here also. My name is Francisca Hernandez and this is Ona Porter, and actually we are doing the same testimony together.

Senator **Bingaman**. OK.

Ms. **Hernandez**. We want to be more effective by sharing it. Let me give you a copy of it, because we will be making reference to some charts. That will help you understand.

Senator **Bingaman**. Thank you.

Ms. **Hernandez**. The first thing is that we feel very excited, that there is this specific legislation for health promotion and disease prevention. We're very excited about that.

There's a tremendous need for it. And that's one of the key—to change things around, because this Nation talks a lot about prevention, but there has never been a real legislative effort of doing something about it.

The other thing that I want to mention very quickly before we go into the body of our testimony is that our view of health is very different from that of most people's. We look at health in a very comprehensive way. We look at health in a wholistic fashion, with a double "w" in front, meaning that health is anything that affects the well-being of people.

Therefore, your physical health depends on your mental and emotional health, which together form the spiritual well-being that you have.

Your well being depends on your socioeconomic condition and your socioeconomic condition depends on how much power you have in the society that you live in.

In our efforts working with the communities that we represent, mainly the non-pueblo communities in the Albuquerque area, plus the urban populations of Albuquerque and Denver, we have discovered that the piecemeal approaches are not going to cut it.

We can work with the schools in isolation, and that's not going to cut it. We can work with economic development alone, and that's not going to cut it. We need to take a much more comprehensive effort if we are going to make any difference.

Ona will interrupt at times, so that we don't leave things out.

The solution that we have found is what we are calling a community health model system. This is an interconnected approach to the root causes of the pathologies the communities are facing. If you look at illustration B in the testimony that I gave you, it is a chart about what a community health model looks like.

And at the center of it, it has the health promotion and disease prevention as a goal for the entire community.

And then around it, the different components of it, starting with primary health care to communications, roads, media or the organizations in the community; the educational system, including schools, literacy for people, and so on.

One important issue to recognize is that while everybody is talking about education, the illiteracy rate among many people is enormous. There are many people who do not know how to read and write.

Even those who know how to read and write don't have enough social literacy to function capably in the world they live in. So we're talking about information that for you and I is very logical, but for somebody that doesn't have the level of literacy that it requires to use it effectively, it's not logical at all.

We're also talking about including community education—continuing education for those people who are already professionals or trained workers and community education as a whole.

We need to reorient other social services, including legal, cultural and spiritual, when I speak of spiritual issues I'm not talking about religious services, but the things that make people feel good inside, what allows them to be creative, contributive and healthy.

We need industry free of toxic substances, agriculture that can produce a food base, land protection, water quality and so forth.

These are the different areas that must come together in order to really work towards the health of people. The outside of our model reflects the community involvement at the grassroot level, and communication with entities and communities outside the local boundaries. The knowledge from people inside the community is important but there is a lot of expertise outside that they need to utilize.

Utilization of community wisdom and expertise along with technical assistance and external resources from outside will give them a solid base for development.

We emphasize in our testimony the importance of incorporating elderly people, these are the people who have the traditional things that really bring a lot of stability to cultures and societies that are in turmoil because of the vast social and technological changes that they are facing.

We need to capitalize on all the above and specifically in terms of education and—or health promotion. I think we need to capitalize on untapped resources such as women who traditionally have served the role, of healers and nurturers together with expertise that they have today in terms of technological knowledge. Women have become very effective in both, the traditional and the modern ways.

Because they are still in charge mostly of the health care of children, family planning and the wellness of their household, they are a tremendous resource for the community to capitalize on.

Women's groups working together in this area offer a great potential for health promotion.

Community resources are also important in terms space and labor, materials, capital and in kind services, both economic and social.

Federal, State, corporate, and other resources can be pooled together to really achieve the socioeconomic development that they need.

The communities themselves should administer and manage this model or this effort. They need a lot of external advice and managing resources, because the dynamics of socioeconomic life are changing constantly in our society.

This requires a tremendous political commitment, not only from Congress, but from the State and from the tribal communities as well.

Besides the legislation a very strong national health policy that is supported by the local health policies, is needed. You're already taking a step with the legislation. Others must work on the policies.

One of the things that I want to mention quickly is that to make health and wellness the individual and collective goal requires that we look at the quality of life, of people. That is really what we're looking for.

Essentially to do that, we're talking about things that other people are disregarding. For instance, how we invest. If we invested in wellness what we have invested in illness, we could prevent not only diabetes, as somebody was saying this morning, but we could prevent practically anything.

We also need to clearly define the difference between prevention and early identification of a condition that is already there.

And many people are confusing these two approaches. When you are identifying something early, that something is already there. When we're talking about preventing something, we are referring to what is not yet a problem.

Ms. PORTER. Another chart that we would like to refer you to, Senator, is this model which shows essentially the system that we propose, which means putting wellness at the center of communities, wellness as our goal.

And for us, wellness means pride and self-esteem, productivity and strength for the entire community. And in order to—in order to achieve that, it has to be the filter through which every decision is made.

If we're not making our decisions that way, then we have horrendous circumstances to overcome in our futures. And some of those that have already happened on Indian reservations and really in the larger society, is we continue to build housing and assign residents to it without regard to their clan relationships, without any provision for the maintenance of the former way of life that the residents are bringing with them, or without considering the family supports that they are leaving behind and nothing to replace them.

We continue to divide—build roads that divide and isolate different community segments. We continue to build schools that in no way address our reality or our needs. We develop enterprises that add badly needed dollars to tribal coffers, but simultaneously create environments of decadence.

We also exploit resources that destroy the very essence of our lives, which is essentially clean air, clean water, and fertile lands. And we have done all of that by having economic power as the center of our need and of our decisionmaking.

We would like to refer to you what happens just in one segment when a community decides to take this approach, a wellness approach, and develop their economic resources with wellness in mind.

And there—where we have shown you the philosophical view of a community that has taken this approach on economic development. And it clearly states that the people of this community will not pollute our air, destroy our land, deplete or endanger our water supply, promote corruption, erode our culture, hurt our youth, encourage dependency or alcoholism, or weaken our people's position or status.

And they have also stated what it is that they will promote, social and economic stability and security, sobriety for our people, the development of capable young people, individual and collective responsibility, personal growth and development, the inner-dependence of our people, and pride in our cultural heritage.

In every aspect of the proposed system, we must do the same thing. And this book represents for the community that we're speaking of here how they have done that in each one of the areas that is represented here, departing with this philosophical statement.

Now, it may seem absurd to say we need a philosophical statement and that folks in the community can come up with that. It is done through a very simple dialog process that goes on for quite a long time, which clarifies for the people what they believe and what they want.

Once a document like this is prepared and agreed to by the community, the means and the ability to make decisions become very clear.

Ms. **Hernandez**. I want to say that so far the effort Indian Health Service is making is basically a medical model. And in the medical model, resources are allocated for illness and poverty.

In the community health model, the resources are allocated for wellness and prosperity. I believe that at this point we don't even need to have increases to the budget we already have in order to modify the model by which we provide services. With the same budget we have, we could implement a community health model system.

In the community health model system, we face problems of accessibility, whether it's geographic, financial, or functional, functional thinking of management or leadership. These can be corrected by reorienting our goals.

With the community health model system we have a more effective utilization of inside and outside resources. Budgetary allocations are given simultaneously with responsibility and authority to make internal decisions.

With this brief information, we conclude our testimony.

Senator **Bingaman**. That's fine. We appreciate your testimony very much.

[The joint prepared statement of Ms. Hernandez and Ms. Porter follows. Text resumes on p. 291.]

Prepared Statement of Francisca Hernandez and Ona Lara Porter of the Albuquerque Area Indian Health Board, on Behalf of the Tribes and Communities Represented Therein

We represent the Albuquerque Area Indian Health Board, Inc., and are here to testify on behalf of the tribes and communities represented therein; the Jicarilla Apache Tribe, Mescalsro Apache Tribe, Alamo Navajo Chapter, Canoncito Band of Navajos, Ramab Navajo Community Chapter, Southern Ute Tribe, Ute Mountain Ute Tribe, and off-reservation populations within the Denver and Albuquerque metropolitan areas.

Prevention concepts have long held the interest of tribal planners and service providers as well as the Indian Health Service, local and national advisory boards and people in general. An underlying interest in community health model systems has been somewhat confused with the public health care systems.

The main goal of a community health model system is to achieve the mental, physical, emotional and socio-economic well-being that allows individuals the state of wellness, strength and productivity required to improve the quality of life. With wellness as the focus, the developmental process becomes an integrated effort between the health systems, the social and economic sectors and individuals' self reliance. The first step in this endeavor is to address the need to create a sense of community among the members of the tribe. This must be achieved before a developmental model can be successful. Any plans or implementation of services within the goal of development require that both plans and implementation evolve or emerge from the socio-economic conditions and the social values of the group that make up the community. Only then can one incorporate the promotion of health and the prevention of illness as integral components of overall health development.

Right now health care systems, whether for prevention or for curative efforts, are devised outside of the mainstream of the socio-economic reality. To have an effective health promotion or disease prevention effort the goals must be determined by the larger social goals and those can only be attained by social and economic means.

Experience has shown that, whether we are speaking of underdeveloped communities in third world countries or in the United States, to have an effective health policy it is necessary to allocate resources to people on the social periphery in order to satisfy their basic needs first. Only then can the overall improvement in the community health situation can be accomplished. How can we achieve economic development, food production, adequate and safe water, sanitation, housing, environmental protection and education in a way that coordinates with other sectors to create a healthy community? Strong political support, both at the national and community level, reinforced by a firm national strategy and strong legislation forms the power base for an approach of this kind. There will be opposition because many economic planners and groups believe that economic growth alone will bring the solution to health problems, just like many health planners believe that isolated and specific issues such as family planning will bring the solution. Economic development alone or family planning alone can bring improvements in health but on a limited scale. A more comprehensive and integrated approach is necessary. An approach of this sort will include all the other specific issues such as nutrition and control of hypertension but within a larger picture or model.

The integration of physical, mental and emotional health with the socio-economic development of the community encompasses not only the building of an infrastructure where one is not available and incentive for community enterprises, but also the development of a strong school system, effective leadership, stable administration and familiar patterns, cultural activities, religious organizations, the performance of the arts, recreation, the effectiveness of a judicial system and the expansion of knowledge and technologies. (See illustration A of "A Community Health Model System".)

When considered from this wholistic understanding, health expenditures can only be seen as a mandatory investment in the economic and social development of the community and of this nation. Development implies progressive improvements in the living conditions and the quality of life enjoyed by society and shared by its members. Economic development is necessary to achieve most social goals and social development is necessary to achieve economic goals. Only when they have an acceptable level of health can individuals, families and communities enjoy the other benefits of life, and in turn become active in the production of life benefits. Therefore, any distinction between economic, social and health development is not tenable.

There is an incorrect assumption which pervades current health policy that says we need to find the cheapest form of medical care for the poor with a bare minimum of financial and technical support. Thus, it is truly inspiring that our senator from New Mexico is interested in investing energy and resources in a more qualitative approach to the health of Indian people. His political intervention is a gigantic step in overcoming this attitude because only this type of intervention coupled with forceful explanations of the real purpose and scope of health promotion can begin to turn the wheels of the pathological web that we face in underdeveloped communities. Political commitment requires a reorientation of national health strategies. This includes a transfer for reallocation of other socio-economic resources.

Health is not only the right of everyone but the responsibility of everyone as well. Therefore, community participation in which individual families assume responsibility for their own efforts at a more qualitative health and welfare and for that of the community as well is of utmost importance. But in order to achieve this level of consciousness, the people need a sense of community, education, and the feeling of hope and excitment about a more prosperous future. Involving the community in the educational process of planning to address their needs is more than just calling them for meetings. It requires a true grass roots mobilization. Training is necessary as a continuous process by which individuals and families are incorporated into the development team under the direction of a capable leader. The need for technical guidance and supervision that is intended to achieve growth in the individuals and not as an exercise in power also must be acknowledged.

Accessibility is an important issue that must be understood and addressed on several levels. Simple country roads that are kept on a regular basis is a relatively inexpensive means of bringing people together. Financial accessibility which is created through the organization of credit unions, is also a simple but valuable way to meet both personal and community needs. Functional accessibility can be achieved through proper management and leadership that does not lose sense of what the overall picture is. In some communities the situation is more complex. Often a philosophical reorientation is necessary before any kind of change can begin to take form. We have communities with well established infrastructures that are highly developed economically yet the pathologies are the same as in the poorest community in our area. It is not uncommon to have those more advanced in economics still with 60-70% unemployment, with alcoholism impacting 100% of the population directly or indirectly and with a level of school performance far below the national average. Thus, accessibility is not only important in terms of quantity but of quality as well.

Some kind of agricultural policy is also necessary. The production of food by families for their own consumption would insure that the quality and variety of food available would improve substantially. This is a significant way of improving the nutritional status of the people. In some cases patterns of agriculture must change to adapt to the ecological and social reality of today. The study on hunger done by the Harvard University School of Public Health demonstrated that hunger and malnutrition are a reality for Indian people in proportions unacceptable to the economic status of this country. Accessibility to fresh foods, fruits, vegetables and other necessary staples is one of the main problems. Much of this situation can be addressed through agricultural initiatives which include local production, preserving, processing and exchange.

Indigenous health practitioners can become important allies in organizing efforts to improve the health of the community in this wholistic fashion. Women's organizations should be encouraged. Traditionally, women have been central to the promotion of health for their families. This makes them a key group in the health promotion effort. They can deal with the issues of nutrition, child care, sanitation, child rearing and family planning as well as with the overall socio-economic reality. Today women have the advantage of being versatile in both worlds.

Careful screening of the type of industrial activities that are permitted in the communities can prevent greater health hazards or risks. Avoiding water and air pollution, toxic chemicals and other conditions that could be detrimental to the overall environment and health of the community is fundamental to the concept of disease prevention. It is ridiculous to try to prevent cancer in an area where uranium mining has contaminated the land, the water supply and all other resources as well.

Housing that is properly adapted to the local ecological circumstances has a significant effect on health as well as on socio-economic well-being. In parts of our sunny and clay-rich southwest, solar adobe construction could be much less expensive, more attractive, and energy saving, longer lasting, and less in conflict with traditional life styles than what HUD has practiced for years in the building of houses on the reservations, Solar adobe structures are easier to keep clean and have a lower maintenance cost. By community members providing in kind resources in terms of labor and building materials for the construction of homes and other facilities the cost to the government would be significantly reduced and the sense of ownership which is essential to appropriate use and up keep is accomplished.

Budgetary allocations need to be accompanied by the simultaneous delegation of responsibility and authority. Communities should be given a certain financial ceiling and the responsibility to use that money in addition to their own in kind or in cash resources to develop what they have planned and budgeted for. Managerial control should come from the community with technical guidance from other levels of expertise. To evaluate we must measure relevance, progress, efficiency, effectiveness, and impact—not merely cost effectiveness.

The cost effectiveness of the community health model, as opposed to the currently practiced medical model, can be inferred from various points. First, it is an integrated approach which focuses all available resources on a common goal. Second, it has individual and community self-reliance as a primary premise which implies the assumption of a greater responsibility for individual and collective wellness with the passage of time. Third, it invests heavily in prevention and health promotion which also, over time, will reduce the health risks in a given population and the demand for expensive clinical services.

On the other hand, in the strictly medical model, as proposed by the present administration, resources are allocated for illnesses which have reached crisis levels. With no means to address the health status of a population, this approach can only become increasingly costly and less effective. (See illustration B and C, "Medical Model Costs", and "Community Health Model Costs", respectively.)

Because the community health model, not only provides specialized curative services, but also supports activities that promote health and prevent disease while integrating the major social and economic sectors, the productivity of people increases, the demand for quality education is greater, the expectations of people are raised, and their job and enterprising incentives are enhanced. But, this process takes more than a year to be accomplished. It demands stability and security in policy, practice and funding criterion.

In summary: (1) Legislation would be required to facilitate this kind of social development effort; (2) The development of a national policy conducive to this approach is also necessary; (3) Unequivocal political commitment form both Congress and the tribal communities is a must; (4) Community involvement is essential; (5) Administrative reform will be required in many instances; (6) Financial alterations which include the allocation of resources, pooling of resources between the Federal Government, the State, the tribes and the attraction of investors must be addressed; (7) A plan of action that will include a time line, resources, required and clearly defined roles and responsibilities must be created; (8) A clearly defined path of where the plan of action is leading which includes programs, design, processes and mechanisms to accomplish them, appropriate technology reorientation of existing programs, guidelines, support from other sectors, monitoring and evaluation also must be created; (9) Regional strategies for the purposes of information exchange, technical cooperation, networking, research and use of national and local expertise need to be employed.

The idea of a demonstration project under the direction of a multi-skill pool of resources such as a university is a good one. Most communities are reluctant to take risks by themselves but under the security of a body of knowledge such as a university offers, they would be more open to change. Communities also prefer to see a model that has worked out its kinks and growing difficulties that they can adapt to their needs and resources.

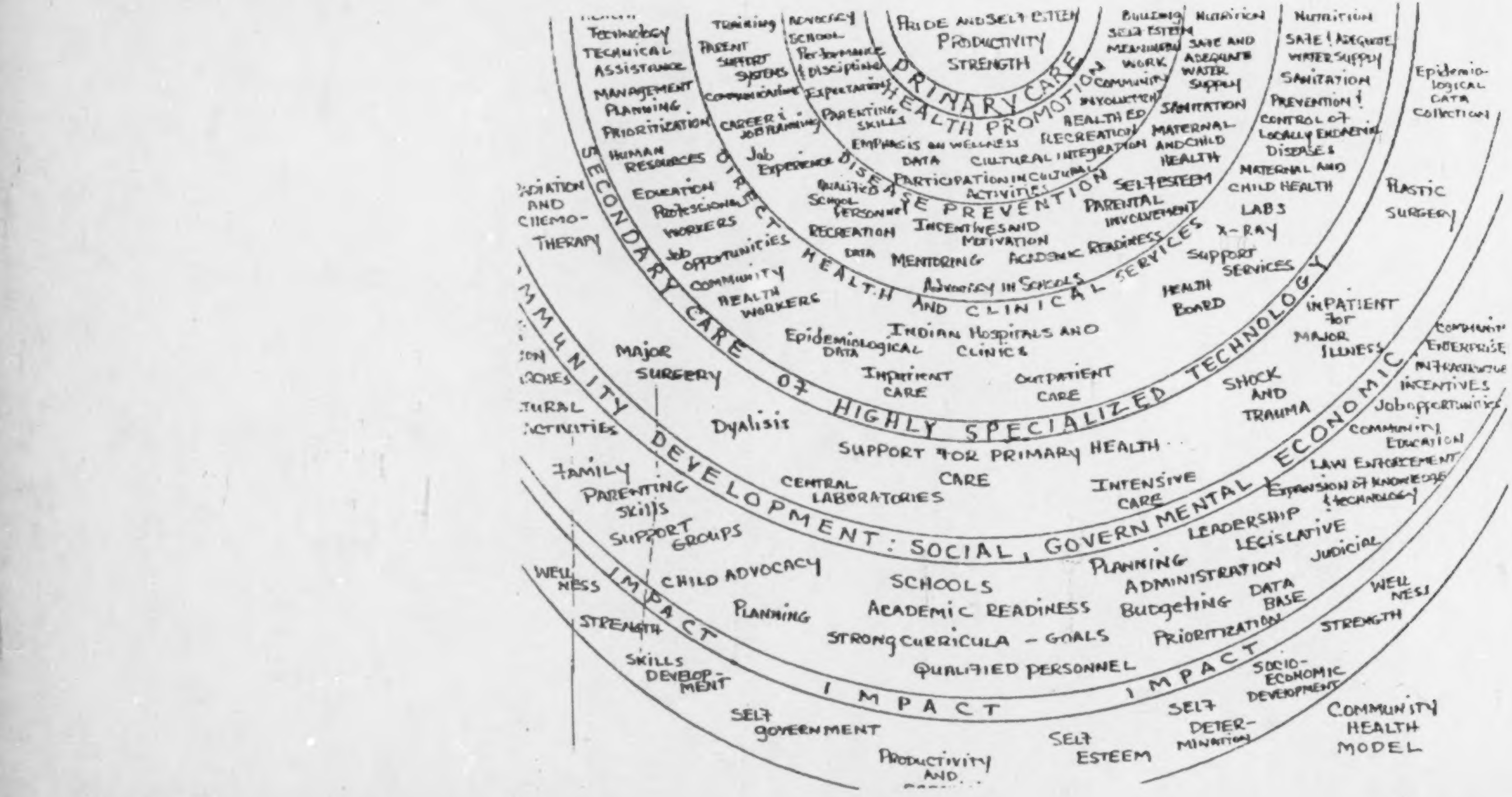
Primary health care as a functional part of this understanding will address effectively and efficiently the issues under the disease prevention category as outlined in the Senate Bill 400, immunizations, control of high blood pressure, control of sexually transmittable diseases, family planning, pregnancy and infant care, control of toxic agents, occupational safety and health, control of accidental injuries, fluoridation of water and control of infectious agents.

In terms of the health promotion issues, a community development approach of this scope will certainly reduce many of the existing stresses the people face today and will enable people to better cope with the new stresses that will emerge. Stress is always present. It is our ability to cope with it, reduce it or resolve it that changes. A general reduction in the use of alcohol and drug abuse will only take place within this socio-economic development approach because alcoholism besides being a disease, is also a symptom of a bigger malaise called powerlessness, hopelessness and a lack of skills to affect and control our personal circumstances.

In order to improve nutrition, people need the means to acquire a better quality and variety of food and the education to pass the judgment that will allow them to make better selections from what is available. Both of these requirements are socio-economic in essence and logistics. Cessation of smoking and improvement of physical fitness are easier to incorporate in the proposed socio-economic environment than just trying to convince people to do something they have little understanding of.

To truly have development, we must depart from the perceptions people have and their personal and group experiences. This is then put together within the historical and cultural context people have created. The problems are posed and an interconnected approach in the form of action plan and strategy follows. It is important to do this interconnectedly because in the development process and the problem solving experience perceptions, experiences and culture change. This is the most secure means to insure that the Indian communities regenerate themselves within the national socio-economic context through genuine development and social collaboration.

Strategies can be developed to create this model within the existing resources provided by the Federal Government through Indian Health Service and Bureau of Indian Affairs.


PRIDE AND SELF ESTEEM
PRODUCTIVITY
STRENGTH
PRIMARY CARE
HEALTH PROMOTION
DISEASE PREVENTION
DIRECT HEALTH AND CLINICAL SERVICES
SECONDARY CARE OF HIGHLY SPECIALIZED TECHNOLOGY
COMMUNITY DEVELOPMENT: SOCIAL, GOVERNMENTAL, ECONOMIC
IMPACT
IMPACT
IMPACT
Technology
TECHNICAL ASSISTANCE
MANAGEMENT PLANNING
PRIORITIZATION
HUMAN RESOURCES
EDUCATION
Professional WORKERS
Job OPPORTUNITIES
COMMUNITY HEALTH WORKERS
Training
PARENT SUPPORT SYSTEMS
Communication
CAREER & JOB TRAINING
Job Experience
ADVOCACY
SCHOOL Performance & Discipline
Expectations
PARENTING SKILLS
EMPHASIS ON WELLNESS
DATA
CULTURAL INTEGRATION
PARTICIPATION IN CULTURAL ACTIVITIES
Qualified School Personnel
RECREATION
INCENTIVES AND MOTIVATION
DATA
MENTORING
ACADEMIC READINESS
Advocacy in Schools
HEALTH ED
RECREATION
Building SELF ESTEEM
MEANINGFUL WORK
COMMUNITY INVOLVEMENT
NUTRITION
SAFE AND ADEQUATE WATER SUPPLY
SANITATION
MATERNAL AND CHILD HEALTH
SELF ESTEEM
PARENTAL INVOLVEMENT
NUTRITION
SAFE & ADEQUATE WATER SUPPLY
SANITATION
PREVENTION & CONTROL OF LOCALLY ENDEMIC DISEASES
MATERNAL AND CHILD HEALTH
LABS
X-RAY
SUPPORT SERVICES
HEALTH BOARD
Epidemiological DATA
INDIAN HOSPITALS AND CLINICS
Inpatient CARE
OUTPATIENT CARE
Epidemiological DATA COLLECTION
PLASTIC SURGERY
INPATIENT for MAJOR ILLNESS
SHOCK AND TRAUMA
ADIATION AND CHEMO-THERAPY
MAJOR SURGERY
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SUPPORT FOR PRIMARY HEALTH CARE
CENTRAL LABORATORIES
INTENSIVE CARE
ION
ACHES
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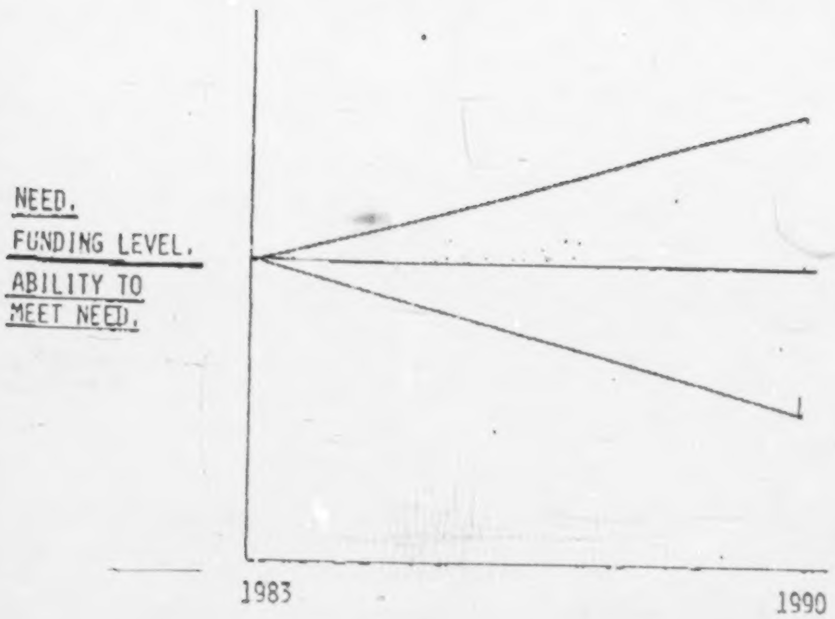
FAMILY
PARENTING SKILLS
SUPPORT GROUPS
CHILD ADVOCACY
PLANNING
SCHOOLS
ACADEMIC READINESS
STRONG CURRICULA - GOALS
QUALIFIED PERSONNEL
PLANNING
ADMINISTRATION
Budgeting
DATA BASE
PRIORITIZATION
LEADERSHIP
LEGISLATIVE
JUDICIAL
COMMUNITY ENTERPRISE
INFRASTRUCTURE INCENTIVES
Job opportunities
COMMUNITY EDUCATION
LAW ENFORCEMENT
EXPANSION OF KNOWLEDGE & TECHNOLOGY
WELL NESS
STRENGTH
SKILLS DEVELOP-MENT
SELF GOVERNMENT
PRODUCTIVITY AND
SELF ESTEEM
SELF DETER-MINATION
SOCIO-ECONOMIC DEVELOPMENT
STRENGTH
WELL NESS

COMMUNITY HEALTH MODEL

ILLUSTRATION B

MEDICAL MODEL



THE MEDICAL MODEL IS CRISIS OR ILLNESS ORIENTED AND RESTRICTS ITSELF TO THE PROVISION OF MEDICAL CARE. IT GIVES RISE TO SYSTEMS WHICH RESTRICT THEMSELVES TO MEDICAL CARE, EVEN THOUGH INDUSTRIALIZATION AND DELIBERATE ALTERATION OF THE ENVIRONMENT ARE CREATING HEALTH PROBLEMS, WHOSE POTENTIAL CONTROL LIES FAR BEYOND THE SCOPE OF MEDICAL CARE. THUS, IT IGNORES THE PREVENTION OF DISEASE AND THE PROMOTION OF HEALTH AND IS COSTLY AND INEFFECTIVE. SHORT FALL, IN THE MEDICAL MODEL, IS EVER INCREASING WITH NO COMMUNITY MEANS TO MEET IT.

IN THIS MODEL:

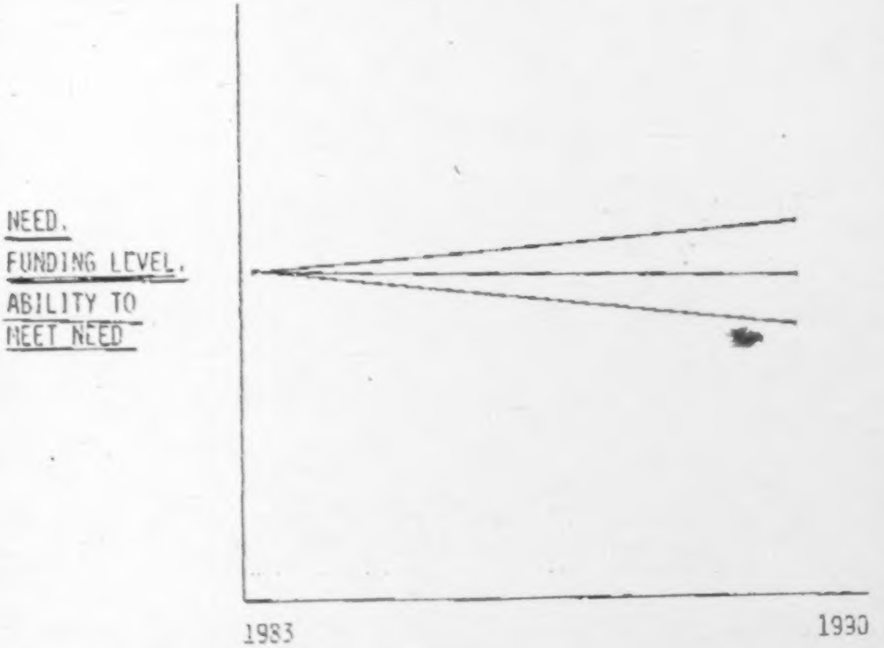
NEED INCREASES DUE TO INCREASED DISEASE AND INCREASED POPULATION.

FUNDING LEVEL INCREASES WITH INFLATION.

ABILITY TO MEET NEED DECREASES WITH INCREASED DISEASE, POPULATION, AND COST OF SERVICES.

ILLUSTRATION C

COMMUNITY HEALTH MODEL



THE COMMUNITY HEALTH MODEL EMPHASIZES HEALTH AND WELLNESS, AND VIEWS BOTH AS INTEGRAL PARTS OF OVERALL ECONOMIC AND SOCIAL DEVELOPMENT. WITH A HEALTH PREVENTION/PROMOTION FOCUS, DISEASE AND ILLNESS WILL DECREASE. WITH MAXIMUM COMMUNITY AND INDIVIDUAL SELF-RELIANCE AS A KEY ELEMENT, THE SHORT FALL WILL BECOME THE RESPONSIBILITY OF THE TRIBE AND COULD BE MADE UP FORM PROGRAM SUPPLEMENTS FROM STATE AND PRIVATE SOURCES, THIRD PARTY PAYMENT COLLECTIONS, FEES FOR SERVICES FOR NON-INDIAN CLIENTS, AND OTHER SOURCES.

IN THIS MODEL:

NEED INCREASES IN RELATIONSHIP TO POPULATION GROWTH.

FUNDING LEVEL INCREASES WITH INFLATION.

ABILITY TO MEET NEED DECREASES IN RELATIONSHIP TO POPULATION INCREASE AND COST OF SERVICES INCREASE.

Senator **Bingaman**. We also have Ken Reid. Ken, would you go ahead with your testimony?

STATEMENT OF KEN L. REID, EXECUTIVE DIRECTOR, ALBUQUERQUE URBAN INDIAN HEALTH CLINIC, ALBUQUERQUE, NM

Mr. **Reid**. Thank you, Senator, for allowing us to address some of the concerns regarding S. 400.

I represent the Albuquerque Urban Indian Health Clinic, which is a private nonprofit urban Indian organization based in Albuquerque.

The urban Indian population in Albuquerque has been identified at approximately 26,000 people, of which most are—or most of the people there in Albuquerque are a cross-section of all federally recognized Indian tribes here in the United States.

Senator, also in regards to my testimony this afternoon, I am also representing, and I have a copy of a testimony which the American Indian Care Association would like to have me leave in trust with you.

And rather than address specifics in that regard, I would like to, just as a matter of record, leave it for the committee's review.

It is basically the American Indian Health Care Association is in support of S. 400, and has also expressed a concern in regards to urban Indian organizations and programs being—or having access and services to health promotion and disease prevention kind of services.

In general terms, American Indian Health Care Association has 37 projects throughout the Nation, of which are primarily supported under title 5 of Public Law 94-437, the Indian Health Care Improvement Act.

In regards to the Albuquerque Urban Indian Health Clinic and the board of directors of which I am representing, we are in support of S. 400, and have also expressed a concern regarding the inclusion of urban Indians into the language of the bill.

And regarding our testimony, I believe we address specific lines and language in that. Rather than address that this afternoon, I'll go ahead and leave that in trust with you.

I did, however, want to mention a couple of activities in regards to our clinical services that are being provided and how we coordinate some of the activities with the State and with the Indian Health Service.

We are basically supported by Indian grant under title 5 under Public Law 94-437, which the fiscal year, it will end, of course, on September 30 of this year.

In regards to the reauthorization of Public Law 94-437, or perhaps the consideration of S. 400, I believe urban Indian kinds of programs, prevention programs, screening programs, or providing some kind of interpretative services for patients or for Indian people who don't understand the language, they have to commute into Albuquerque, and we will cease to exist in that regards.

Indian Health Service basically in the Albuquerque area provides limited health care to urban people. As an example, contract health services, if there are regulations in that regard which restricts services to urban Indians, if you leave your reservation, I believe it—and correct me if I'm wrong, Francisca, 180 days, once you leave your reservation, you lose your eligibility, if you do not reside on or near your Indian reservation.

In regards to urban Indians, they travel from—it may be from Navajo, it may be Koiwa's from Oklahoma, may be from Taos Pueblo, who reside in Albuquerque and are deemed not eligible for contract health services.

Because of that, it poses a great deal of problems, a financial burden basically on the families, the children, the individuals in regards to being able to pay for some of the medical care, which may be a need.

Aside from that, they may be referred back to their tribe in order to seek that specialized care, but of course, you know, as it is, back in the 1950's, I believe, which is addressed in the American Indian Health Care Association testimony, there is a reallocation—or relocation, excuse me, plan with the Bureau of Indian Affairs which is established to help promote and relocate Indians to metropolitan areas to seek jobs, education, attend Indian schooling kind of things.

And thereafter, I believe a lot of urban Indian people were being adjusted to the ways of life off the reservation.

Once they get educated and find that they have to go back to the reservations, they find job employment is very minimal, they find quite a bit of problems in regards to education, of course, limited health care as well.

And so as a result, I believe a lot of urban Indian people are subjected to a lot of barriers to health care at the present time, Senator.

Rather than continue on, I'd like to—if you have any questions in regards to our clinic, the type of services that we are providing, I'd be glad to entertain any questions this afternoon.

Senator **Bingaman**. OK, let me thank you all. We are running behind about—nearly an hour now, and we've got four more witnesses, so I think I'll just defer asking any questions and thank you all very much for the testimony. We'll include it all in the record, and if I can think of questions once I get a chance to review it all, I may write you at that point.

Mr. **Reid**. OK.

Senator **Bingaman**. Thank you very much.

Mr. **Reid**. Thank you, Senator.

[Mr. Reid submitted a letter of support on S. 400 from the Albuquerque Urban Indian Health Clinic, an enclosed summary of the bill, a prepared statement of the Albuquerque Urban Indian Health Clinic, and a prepared statement of the American Indian Health Care Association. Text resumes on p. 305.]

albuquerque urban
indian health clinic, inc.

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EXECUTIVE DIRECTOR
[redacted]

BOARD MEMBERS

CHAIRMAN
William Douglas Lee

VICE-CHAIRMAN

SEC./TREAS.
W.W. Frazier

Bob Martin

Luci Tapahonso

May 24, 1985

Honorable Senator Jeff Bingaman
United States Senate
502 Hart Building
Washington, D.C. 20510

Re: Senate Bill 400

Dear Senator Bingaman:

On behalf of the Albuquerque Urban Indian Health Clinic, I appreciate your continued support you have afforded for our Urban Indian people which are representative of most Indian Tribes throughout the Nation.

The enclosed summary has been developed which outlines specific concerns of S. 400 "Indian Health Promotion and Disease Prevention Act of 1985."

The Albuquerque Urban Indian Health Clinic, supports your efforts and endorses the Bill which provides the highly needed service of health promotion and disease prevention services. Your highest consideration in securing some time for presenting our written testimony is highly appreciated.

For the Albuquerque Urban Indian Health Clinic, I remain

Sincerely,

for

Rev. William Douglas Lee
Chairman, AUIHC Board of Directors

ENC.

cc: AUIHC Board of Directors
Files

304 San Pablo S.E. • Suite C • Albuquerque, New Mexico 87108 • (505) 262-2481

Summary Statement
of the
Albuquerque Urban Indian Health Clinic, Inc.
on
S. 400 "Indian Health Promotion and Disease Prevention Act of 1985"

Mr. Chairman and Members of the Committee, we come before you today to present testimony on some of the unmet, vital needs of the Albuquerque Urban Indian Community. The Urban Indian people who reside in The City of Albuquerque, County of Bernalillo, are unique in their socio-economic, medical and health care needs as compared with our homeland reservations. The Urban Indian Community has been identified as coming from the Navajo, Pueblo, Kiowa, Commanche, Ute, Apache, Sioux, and from all other Tribes from throughout the United States. According to recent population statistics, the Urban Indian Community has been identified at 26,000 people and is increasing at a constant rate. Despite the varied Tribal Traditions and Cultural Values that our Urban Indian people represent, the health and medical problems are similar.

Our written testimony addresses some major unmet needs and concerns, with regard to specific issues as addressed in S. 400. This Bill has been long overdue, and we look forward to its passage by the United States of America Congress and signature of the President.

Language of the Bill is inadequate in addressing the Urban Indian health promotion and disease prevention unmet needs, specifically:

Sec.2, (2); recommend "Urban Indian designated Agencies," become part of the coordinating efforts;

Page 2 Line 5: recommend that the word "should" be stricken and replaced with "shall"; and

*Page 2, Line 6: recommend that the word "Indians," be inclusive of "Urban Indians,"

*: Indian Health Services are limited to Urban Indian populations, thereby making it inaccessible to Urban Indians, if the language is not clear and concise.

Page 2, Line 11: recommend that the following become part of the priority health promotion, namely:

(A) Dental Hygiene
(B) Wellness and Healthful Living
(C) Suicide Prevention

Page 3, Section 203: recommend that under Line 23, a subsection be added to read "(1). A special assessment of the health promotion and disease needs of Urban Indians and the degree of each of such needs," be included.

Note: The accessibility and availability of health and medical services to Urban Indians are not defined. Most existing Urban Indian Health Programs as ours, have historically placed an emphasis in defining these barriers to health care. However, with limited resources, this becomes a never ending task.

Page 4, Line 20 through 25; omits our Urban Indian Population; it is highly recommended that the language include Urban Indian Organizations.

Other major concerns are further noted in our written testimony, with supportive appendices and statistics. This Summary is merely an introduction statement of our testimony. Your highest and favorable consideration for the presentation of our document is appreciated.

TESTIMONIAL STATEMENT

OF THE

ALBUQUERQUE URBAN INDIAN CLINIC

ON

S.400: Indian Health Promotion and Disease Prevention Act of 1985

Presented To: Senate Select Committee
On Indian Affairs

June 1, 1985

Mr. Chairman and members of the Senate Select Committee on Indian Affairs, my name is Ken Reid, Executive Director of the Albuquerque Urban Indian Health Clinic, which is a private non-profit Urban Indian Organization, located in Albuquerque, New Mexico. The Urban Indian population in Albuquerque being identified at 26,000 people, represent a vast cross-section of all federally recognized Indian tribes of the United States.

Mr. Chairman and members of the Senate Select Committee, my presentation is two-fold in which I also represent the American Indian Health Care Association, as a Board Representative for Region VI. Enclosed in your testimonial packets, is the position statement of the Association, which supports and endorses S.400. The Association which is comprised of thirty-seven urban Indian health programs through-out the nation, believes health promotional disease prevention activities, are important and necessary not only on the reservation, but also within the urban areas, which are served by their thirty-seven urban Indian health programs. Mr. Chairman and committee members, the Association leaves with you specific concerns as defined in our testimony and would like to go on record of this testimony being submitted for your review.

Mr. Chairman and committee members for your information and record and as part of my second report, the Albuquerque Urban Indian Health Clinic supports your endeavors and seeks your support for the passage of S.400, with the Inclusion of Urban Indian to the Language of the Bill, where there is mention of "Indians" and "Tribes".

There is indeed a great unmet health need on our Tribal Reservations, by which our homeland communities, are not able to provide any support for our urban Indian people. The continuing budget reduction, for Indian Health Service, and the massive budget reduction plans for social and public health services futher compounds our abilities, to improve the health care of Urban Indians to parity with the general U. S. population (i.e. see original Bill of P.L. 94-437).

The Urban Indians are subjected to many barriers to health care (see Association testimony) coupled with this finding were the facts that:

- the health status of Urban Indian people was below that of the general U. S. population (see Tribal Specific Health Plans of I.H.S. - developed under the original Directives of P.L. 94-437). The disease and mortality rates among Urban Indian people was just as high as and in some instances higher than, the rates for Indian people living on reservations.

- The infant death rate among Indian people in the metropolitan area was higher than, the rates for Indian people living on reservations.

- Many Urban Indian people experienced barriers to obtaining needed services and required assistance in gaining access to local community health services.

- Many Urban Indian people could not afford to pay the increasing costs of health care and in most cases not eligible for Contract Health Services due to present I.H.S. requirements.

- Specialized health care (i.e. orthodontic svs., minor/major surgical services, skilled nursing and home health services, ---) is non-existant therby placing amazing burdens and accessible problems to health care.

- Existing resources are not culturally sensitive and therefore are ineffective and inadequate in meeting individual and family needs.

Specific health problems addressed in the Albuquerque Urban Indian Health plan, defines the following as unmet needs by which S.400 should seriously consider. Please note that these concerns are of a common problem area for the Urban Indian community in general.

- Reduction in the misuse and abuse of alcohol and drugs,

- Improvement of nutrition,

- Improvement of physical fitness,

- Control of stress,

- Suicide prevention,

- Wellness and healthful living,

- Culturally sensitized family planning svs.

Language as addressed in S.400 is inadequate in assuring Health promotion and disease prevention activities to Urban Indian populations. If the language omits this clause the Urban Indian community will continue to become secondary to Reservations. For example, a concentration of health, medical and social services to Indian people were organized under P.L. 93-638 and P.L. 94-437. Only one segment title V of P.L. 94-437 and none of P. L. 93-638 were addressed to the Urban Indian population.

Mr. Chairman, and committee members the following is submitted requesting your attention to specific section, of this Bill namely:

page 2, line 5: the word "should" be stricken and recommend replaced with "shall".

page 2, line 6: recommend that the word "Indians", be inclusive of "Urban Indians,"

page 3, section 203: recommend that under line 23, A subsection be added to read "(1). A special assessment of the health promotion and disease needs of Urban Indians and the degree of each of such needs," be included.

page 4 "(3) lines 21 through 25: recommend that after each word "Tribe", a comma should be inserted and the word "Urban Indian Organization" be included.

page 5, line 24 and 25, also page 6 line 1 and 2: recommend that a demonstration Urban Indian project/s, be included in the language.

page 6, line 13-15: recommend that the words Urban Indians be included in the language.

page 8, line 10 entitled "Community Health Representative Program": recommend that the intent of the entire section include both on and off reservation (Urban Indians).

Mr. Chairman, and honorable committee members, the Albuquerque Urban Indian Health Clinic, which serves the 26,000 Urban Indians in Albuquerque, endorses and supports your efforts in the passage of S.400, and submits this testimony for your highest consideration.

On behalf of the American Indian Health Care Association, and deemed their representative for this hearing, the testimonial statement also endorses your endeavors,and looks forward to its passage.

We are available at your convenience for further clarification or if in need of additional information. Thank you for your interest and support in the health and well-being of our Indian people.

TESTIMONY

to the

SENATE SELECT COMMITTEE

on

INDIAN AFFAIRS

regarding the

INDIAN HEALTH PROMOTION AND DISEASE PREVENTION ACT of 1985

on behalf of

THE AMERICAN INDIAN HEALTH CARE ASSOCIATION

Presented by: Ken Reid, Board Representative
American Indian Health Care Association
245 East Sixth Street, Suite 815
St. Paul, Minnesota 55101
612/293-0233

Honorable Chairman and Committee members, on behalf of the American Indian Health Care Association, I appreciate the opportunity to appear before you today to discuss the Indian Health Promotion and Disease Prevention Act of 1985. I appear before you today to request the Committee to consider the Health Promotion and Disease Prevention needs of urban American Indians.

According to the 1980 Census, over 50% of the American Indian population presently resides in urban communities across the nation. A large percentage of that population was moved to urban areas as a result of the massive relocation programs undertaken by the Federal Government during the 1950's. This Indian population maintains strong ties with their reservations and the vast majority continue to be tribal members. No act of Congress and no court decisions has ever determined that their status as Indians terminates once they cross the reservation border. Fact, Mr. Chairman, Congress has stated that the Federal Government has a mandated responsibility to provide health care to Indians, including urban Indians, in the Indian Health Care Improvement Act.

The emergence of the urban Indian began during the period of general economic prosperity following World War II. In the early 1950's the Bureau of Indian Affairs (BIA) monitored a Relocation Program for American Indians. The intent of the program was to assist and encourage Indian people to seek employment and education in nearby cities. During the era of Indians migrating to urban areas of cities, they experienced many social and health related problems. Urban Indians were left with experiencing poor individual and societal identity problems, poor health and education problems, poor living conditions and high unemployment rates. As the Indian people continued to move into urban areas, they unknowingly forfeited access to Federal Health Care and

Bureau of Indian Affairs Services. For economic standing, limited work experiences, unfamiliarity with the urban health care delivery systems and cultural differences compounded by the transition to an urban lifestyle produced a low level of health care utilization.

Mr. Chairman and Committee members, President Reagan has stated in his veto message of S.2166, the Indian Care Amendments of 1984, the infant mortality rate has decreased by 77% and the paternal death rate by 86%. The death rate resulting from pneumonia and influenza has decreased by 73% and the death rate from tuberculosis has been reduced by 94% and the incidence of new active tuberculosis has been reduced by 84%.

The facts remain that Congress found that Indians are experiencing the poorest health problems than any population in the nation. Indians are still experiencing major health problem mortality rates that are significantly higher than national population statistics. The major health problems American Indians are experiencing include:

Tubuculosis	500% greater
Pneumonia/Influenza	64% greater
Alcoholism	451% greater
Accidents (automobile)	154% greater
Diabetes Mellitus	124% greater
Homocides	68% greater
Suicides	25% greater

President Reagan's veto message does not indicate the significant health problems that Indians are experiencing. These major health problems and others, are a waste of lives and human potential among Indians.

The current health problems of urban American Indians is significantly higher than that of reservation Indians and the national population. High unemployment, lack of education, inadequate income, absence of affordable insurance coverage, unacceptable health care through existing systems, and complex medical, dental, social problems have contributed to effective barriers between urban American Indians and badly needed health care programs and services. Coupled with these findings were facts that include:

1) The health status of urban American Indians was below that of the national population. The disease mortality and morbidity rates were as high, and in some instances significantly higher than Indian people living on reservations;

2) The infant death rates among urban American Indians are higher than reservation statistics;

3) A recent evaluation of urban Indian health clinics indentified the following major health problems of urban Indians. These include: hypertension, diabetes, alcohol/substance abuse, pre/post natal problems, dental, otitis media, trauma and injuries, obesity, respiratory diseases, infectious diseases and mental health problems; and

4) A majority of urban Indians are experiencing unaffordable, unavailable and unaccessable health care delivery programs and services.

Honorable Chairman and Committee members, the circle of life embodies the philosophical perspectives of harmony with life in the American Indian cultures. Understanding the circle of life is essential in comprehending the philosophical view of Indian people and their culture. It represents the continuity of sharing, oral traditions, conciousness, generosity, extended family and harmony with all living things. In the circle of life, animals symbolize separate and different values; the Eagle represents courage, knowledge, strength and foresight; the turtle represent resourcefulness. Each animal, tree, sky, moon, etc. have their own quality of spirit life.

American Indians traditionally believe that they are a part of all living things. According to Indian health belief concepts, a human is composed of body, mind and spirit. All three are interrelated and function together. Health to Indians is the power to exist and function harmoniously. The spiritual orientation influences the traditional practice. The spirit focus on the relationships between patients and their surroundings and type of ceremony. The reasons for ceremonies are beliefs that disease and illness are the results of lack of harmony between a sick person and his surroundings. To understand the Indians approach to healing include the emphasis is on unity of experience; to be sick is to be fragmented; to be healed is to be whole; and to be whole one must be in harmony with family, friends, nature and themselves.

Mr. Chairman, Indian and Alaskan Native people have always been a mobile population. Indians residing in urban areas maintain strong ties with their tribes and mirror the same low health status of their reservation cousins. To ignore the urban Indian population is to abandon the national goal established in the Indian Health Care Improvement Act, "...of providing the highest possible health status to Indians...". The American Indian Health Care Association and the 37 health programs it represents have struggled for the last four years to survive and maintain existing services.

Senator BINGAMAN. Alvin Moyle is here from the Inter-Tribal Council of Nevada, and perhaps he could come forward, or at least I believe he's here—well, I guess he's not here, so maybe we don't have four more witnesses.

Ada White I understand is here for the National Association of Community Health Representatives from Montana, and we would like very much to hear your testimony, please.

STATEMENT OF ADA M. WHITE, DIRECTOR, NATIONAL ASSOCIATION OF COMMUNITY HEALTH REPRESENTATIVES, CROW AGENCY, MT

Ms. WHITE. Thank you very much, Senator. My name is Ada White. I'm a member of the Crow Tribe from the State of Montana. I'm here currently representing the National Association of Community Health Representatives.

I think it is very important that we look at S. 400 and how it relates to Tribal CHR health programs. Written testimony has been provided. What I would like to do is just point out some of the more important factors that we are concerned with.

One, we know that Indian Health Service probably does say they are doing a lot in the area of health education and what have you, but what we do know is that the lack of policy, the lack of that have been experencially applied elsewhere has not been made available.

In some reservations, we have extremely effective health education programs, dependent on the philosophy of the service unit and the philosophy of the area office.

In some areas, some reservations, we are hurting drastically for personnel that are interested and concerned and willing to apply resources to health education.

There are some very critical issues that are facing CHR programs today, and one of them is a question of what do CHR's do, to how is CHR time used.

We recognize that a lot of work is done in health education, a lot more has to be done. But we also know that when it comes to sort of critical attitudes, most often preventive health and field health people are the ones that are criticized, one, because a lot of the education does not occur within the structured setting of a clinic or what have you.

But a lot does come through in community activities, at home or other social kind of events. We know that Indian Health Service is very sophisticated in manufacturing barriers in terms of carrying through with contract health care programs or tribal—correction, tribal contract health programs, and we really believe that a prototype is needed. We believe that funds have to be identified that is to be applied by Indian Health Service to health education, and we believe that standardized policies are needed just so that there is an expectation placed on all areas as to what should occur within the health education department.

This has not happened with CHR programs. It is now happening. Perhaps too late, we don't know. The CHR program has been around for 16 years. Within the past 2 years, the standardized CHR program scopes of work were developed. A national reporting system was developed. We now have a front office that was not there in the past, and we find that the policies that are just now being developed are to be accepted and to be applied. Hopefully, they will be accepted by tribal groups and would provide the kind of documentation needed to keep CHR going.

Senator BINGAMAN. OK. Thank you very much for traveling here and testifying, and we'll make all of your testimony part of the record.

[Ms. White's prepared statement, on behalf of the National Association of Community Health Representatives, follows:]

PREPARED STATEMENT OF ADA M. WHITE, PRESIDENT, NATIONAL ASSOCIATION OF COMMUNITY HEALTH REPRESENTATIVES

The Community Health Representatives (CHR) Program was established in 1968 through the Authority of the Snyder Act. Through contractual arrangements between the Indian Health Service and Indian/Alaska Native Governments, tribes were effective in establishing community-based tribal health programs, comprised of well-trained, indigenous staff, capable of providing tribal specific health services.

The CHR Program has demonstrated effectiveness and major accomplishments in the areas of: patient access to and utilization of health resources; tribal health program development and in the provision of health care delivery.

In 1981, the CHR budget was reduced by 21%. There were no program budget increases since then, but repeated attempts by the administration to completely eliminate the CHR Program. The over-all program effects, by funding restrictions, and ominous attempts for elimination has resulted in: staff turn-over, more skilled, well educated person's seeking job security elsewhere; staff distress, morale of program hitting low levels due to insecurity of employment; less emphasis on training and continued training; the abandonment of a centralized data system.

In June, 1982 a report on the CHR Program was provided to Congress by the Indian Health Service. This report was developed by a National CHR Task Force, representative of Indian Health Service personnel; National Indian organizations; tribal health leaders and CHR's. The report covered: narrative descriptions of CHR Programs; CHR Program history; IHS National policy, goal and objective statement; CHR Program scope—health delivery functions, health areas and settings; CHR Program staffing and funding; IHS Program Management Initiatives, program assessment activities. The National CHR Association did work in concert with the National CHR Task Force, and Indian Health Service in the final formulation of this report.

CHR Programs, for the first time since its inception now is operating with uniform guidelines concerning CHR Program scopes of work. In addition, a new CHR reporting system has been developed, and being implemented that ties into the program scopes of work.

Further, as a result of the National CHR Task Force, Indian Health Service Headquarters now has a CHR Director (coordinator) with staff to spearhead CHR issues and promulgate CHR policy. This has never been available in the past, but rather some IHS Program personnel assuming CHR Program duties, "having the responsibility but no authority", "doing this in addition to." It is the opinion of the National CHR Association that this action in establishing "a front office" has: solidified CHR Program efforts; provided a focal point for CHR input in the development of policy (CHRM 84-1 and 84-2)

In a report to Congress in 1977, Dr. Emery Johnson, former Director of Indian Health Service stated that the social fabric of the community must be recognized in the provision of health services. The intent of S. 400 is tailored to respond to the so called social fabric: life style induced illnesses; tribal specific programs; training for health paraprofessionals. This is highlighted in CHR Programs, Sec. 107-6: "explore ways to provide health care, health promotion, and disease prevention to the members of each Indian tribe in a manner which is consistent with the traditional health care practices and cultural values of such Indian tribe." This cultural sensitivity is necessary in addressing the needs of the Indian community.

Indian Health Service may take the position that staff and resources are directed to health promotion and disease prevention. S. 400 clearly focuses attention on the fact that IHS delivers primary health care and often concentrates staff and resources on such care. History points out, when reductions of funds occur, the area hit first is prevention activities. Ironically, Indian Health Service and other health professionals (Dr. Grahmn-HHs), articulate the importance of health promotion and disease prevention, but withhold funds and resources necessary to effectuate service provision.

FY '84, Indian Health Service did establish an ad-hoc CHR training needs committee to determine the skill level of CHR's and the training needed. The work of this committee should not be overlooked. In addition, as stated in S. 400, training should be emphasized, field monitored, on-going, and with tangible results for the community, program and CHR's. More specifically, training be tied into a formal learning institution which would allow for the acquisition of a degree by a CHR.

Sec. 203, point 3, the development of a short term plan and long term plan in the development of a tribal health promotion and disease prevention program must include CHR's in the assessment, identification, planning and application of resources.

Again, history reflects the exclusion of CHR's in local planning efforts, whether intentional or not, experience reflects this. Congress should identify the needed cooperation of IHS, state, tribal representatives in creating a plan best designed, suited and relevant to the Indian community. The tribal specific planning process in the late 70's too often utilized the "canned expertise" of restricted health planners.

Nations of the third world have utilized the CHR program as a prototype in developing health care programs for their people.

Sol Tax, Professor Emeritus of Anthropology, University of Chicago expressed his view: "the unheeded message has been clear throughout history, but now we see how—if we let Indians do it their own way—they might more quickly than we have imagined rebuild their communities." And on reservations and in Alaskan villages, CHR's are crucial to tribal health programs. CHR's are needed, must be included in planning (participatory management is an unknown concept to some IHS and tribal personnel), and recognized for their committment.

Thank you for this opportunity to provide this statement.

Senator BINGAMAN. Since we're running late, and I had already advised people we would have this hearing over before now, I think I'll defer any questions and go ahead with the other two witnesses. Thank you very much.

Michael Bird is a witness from the New Mexico Public Health Association, and if he could come forward, please. How are you? Go right ahead, we're anxious to hear your testimony.

STATEMENT OF MICHAEL BIRD, NEW MEXICO PUBLIC HEALTH ASSOCIATION, ALBUQUERQUE, NM

Mr. BIRD. First of all, I just wanted to say that I'm very happy to have had this opportunity to testify in support of S. 400, the indian health promotion and disease prevention bill.

The New Mexico Public Health Association is a State affiliate of the American Public Health Association and has a vested interest in this area. As an organization, we can count the number of American Indians as members, not to mention the fact that the American Indian population constitutes a significant proportion of New Mexico's population.

We support this effort for a number of basic reasons. First of all, according to the IHS chart series of April 1985, the leading causes of death for American Indian and Alaskan Natives residing in reservation States, 1980 through 1982, was first of all diseases of the heart, and that was followed very closely by accidents.

Another reason that we support it is that in 1984, four out of six Indian age-adjusted mortality rates in comparison to all U.S. rates were behavioral or lifestyle related.

No. 1 was alcohol, which was 459 percent higher. No. 3 was accident rates, which were 155 percent higher, and No. 4 was diabetes, which was 107 percent higher. And followed by No. 6 which was homicide, which had a percentage of 51 percent higher.

Clearly it is evident that there has been a decrease in the—it clearly is evident that there's been a decrease in the past 30 years in health problems related to communicable disease, and an increase in those problems related to behavior al and lifestyle factors, problems that presently cannot be addressed by the traditional western medical care system.

In closing, I would like to say that concepts of holistic health, wellness and running are not new concepts born of the Yuppie Pepsi generation. Indeed, the first practitioners of a holistic perspective on health and the first runners were American Indian people of North and South America.

When one examines literature of historians, linguists, travelers, anthropologists and speaks with American Indian people themselves, they speak of a holistic perspective on life, health and death.

New problems require new approaches. It is clearly evident that a significant number of health problems confronting Indian people are behavioral and lifestyle related. These new problems require innovative approaches which are viable, dynamic and draw upon the cultural values and strengths of Indian populations they are designed to impact upon.

I'd like to just close now with a quote from Peter Nabolkof's book entitled "Indian Running" in which he took a quote from—he quoted a Navajo runner by the name of Rex Lee Jim. And I think this quote very succinctly reflects that perspective of holism and health that I think traditionally and philosophically has always been part of Indian people's world view.

He says, "My grandfather told me that Talking God comes around in the morning, knocks on the door and says, 'Get up, my grandchildren. It's time to run, run for health and wealth." '

I wanted to thank you very much for this opportunity to testify. I think that any kind of—any kind of program changes or innovations has to be built on people, American Indian people's culture and traditional and philosophical perspectives.

And I think to not take an opportunity when there is an opportunity such as this, because as I said, any people's philosophical and traditional perspective was a perspective of holism, was an ecological perspective and was a perspective which reflected an importance on health and fitness. Otherwise, they would not have been able to survive.

And any kind of program that is designed to promote health has to recognize and address values, because that's—that's the key to any kind of a program.

Senator **Bingaman**. Thank you very much for that testimony. I appreciate it, and we will make that part of the record, and thank you again for coming today to testify.

[Mr. Bird's prepared statement, on behalf of the New Mexico Public Health Association, follows:]

PREPARED STATEMENT OF MICHAEL E. BIRD, NEW MEXICO PUBLIC HEALTH ASSOCIATION, ALBUQUERQUE, NM

Mr. Chairman, thank you for this opportunity to testify in support of Senate Bill 400 Indian Health Promotion and Disease Prevention.

The New Mexico Public Health Association a state affiliate of the American Public Health Association has a vested interest in this area. As an organization we can count a number of American Indian's as members, not to mention the fact that the American Indian population constitutes a significant proportion of New Mexico's population.

We support this effort for a number of basic reasons:

1. According to the IHS Chart Series of April 1985. The leading causes of death for American Indian/Alaska Natives residing in reservation states (1980-1982) was from "Diseases of the Heart" followed by "Accidents".

2. In 1984 four out of six Indian age adjusted mortality rates (in comparison to all U.S. rates) were behavioral or lifestyle related.

Number 1, alcohol 459% higher.

Number 3, accident rates 155% higher.

Number 4, diabetes 107% higher.

Number 6, homicide 51% higher.

Clearly it is evident that there has been a decrease in the past 30 years in health problems related to communicable disease and an increase in those problems related to behavioral and lifestyle factors. Problems that presently can not be addressed by the traditional western medical care system.

In closing, I would like to say that concepts of "holistic health", "wellness" and "running" are not new concepts born of the "Yuppie Generation". Indeed the first practioners of a holistic perspective on health and the first runners were American Indian people of North and South America.

When one examines the literature of historians, linguists, travelers, anthropologists and speaks with American Indian people. They speak of a holistic perspective on life, health and death.

New problems require new approaches. It is clearly evident that a significant number of health care problems confronting Indian people are behavioral/lifestyle related. These new problems require innovative approaches which are viable, dynamic and drawn upon the cultural values and strengths of Indian populations they are designed to impact upon.

"My grandfather told me that Talking God comes around in the morning, knocks on the door, and says, "Get up, my grandchildren, it's time to run, run for health and wealth."—Rex Lee Jim, Navajo Runner, Indian Running 1981.

Thank you for this opportunity.

Senator **Bingaman**. The final witness on our list is Ray Begay, who is with the Navajo Physicians and is here in Gallup. Is Ray still here? There he is.

STATEMENT OF DR. RAY BEGAY, CHAIRMAN, NAVAJO COUNCIL OF PHYSICIANS, GALLUP, NM

Dr. **Begay**. Senator Bingaman and members of the committee, thank you for allowing us to participate in the committee meetings for the testimony regarding Senate bill 400.

I speak on behalf of the Council of Physicians. I am delighted to participate in the hearing today and congratulate Senator Bingaman for his efforts for bringing about the Senate bill.

One of the areas that the Council of Navajo Physicians has been concerned with is health trends for the future. In my opinion, this bill is only a start in addressing some of the greatest health problems that will face us in the future.

According to our statistics and those compiled by the Navajo Tribe and IHS, we feel that our current mortality-morbidity rates from accidents, childhood disease, those of early infancy, early disease of the childhood, infectious disease from all sorts and increase in the incidence of cardiovascular diseases, cancer, industrially related accidents, occupational diseases, alcoholism, nutritional disorders and the attendant medical problems, depression, anxiety, chronic medical illness and other health problems that—that have been addressed will face us as one of the leading causes of health problems for the reservation.

Despite the initiative to control some of the medical problems, we have not made progress equivalent to reducing some of the health problems comparable to the rest of the United States.

In the past, health care needs on the reservation have been primarily addressed to acute illnesses. However, due to an emergence of new medical problems on the reservation, we feel that programs directed to the prevention and reoccurrence of these disease processes needs to be instituted.

That approach of medical illness in the Navajo culture has always been met with a lot of mysticism. In reality, disease processes are so much like treatment processes in Western and traditional medicine.

They have difference, yes. There are similarities, and with the similarities that do exist, this is how we can help in controlling some of the chronic and reoccurring medical problems.

Medical illness before it could be adequately treated by the patient's physician, the patient and physician need to have some mutual understanding of the disease process. Their relationship to the patient, the environment, the surroundings and the dynamic processes which originate in the medical illness.

When the reality of certain medical diseases become evident, both to the patient and the physician, they then can start addressing the proper treatment for a given illness.

Like all disease processes, we're left with certain recommendations on how to treat these problems, as far as reoccurrences, prevention and certain medical illness.

These recommendations are always given to the patient. For an example, you leave the doctor's office with a prescription. This prescription in our concept should now involve addressing preventive issues.

This process has been practiced within our tradition of allowing the patient to express some of his needs to the medicineman. Now this is a different concept. We're talking about modern medical problems. And to take some of this concept and turn it around to a concept of preventive medical problems, this has to be addressed.

And in my opinion and in the opinion of the Council of Navajo Physicians, we are delighted that this bill is addressing some of the problems that we have been facing for a long time.

We all feel that medical illnesses are in a dynamic equilibruim between the socioeconomic, various cultures, various political atmospheres that exist in our current society.

We are now subject to new Medicare policies, Medicare review boards and new payments systems for the above medical problems. All these have been instituted within the last several years.

This places a great burden on the IHS, the physicians and everybody else to explore new methods of controlling and placing some of the burden on the physician, and also teaching the patients to help the physicians treat their medical problems.

If we can't develop this mutual relationship with our patients, it increases medical utilization, drives up costs of medical care, and it places the patient at risk of developing more complications of chronic disease processes.

Despite all the problems that we have addressed and taken into account, the bill that you're presenting for the Congress, I feel that this is only a step in addressing some of the chronic and reoccurring medical problems of the people on the reservation.

On behalf of the Council of Navajo Physicians, we endorse this bill in its entirety with a few additions. I feel that there ought to be a separate provision for training of new physicians, health personnel and other paraprofessionals to institute some of these problems that we have as far as preventive medicine is concerned.

I'd like to enlighten you with some statistics that we have currently. IHS currently has about 150 physicians in its entirety on the reservation. This puts a ratio of about 1,000 to 10,000 patients per physician.

Out of these, about four or five of them are practicing Indian physicians. I am one of them. And this places the ratio at about 1,000 to 30,000 or maybe 1,000 to 40,000 patients per one physician.

These are the problems that we're facing. And as Indian physicians, how can we address some of the problems that are facing us in this period of time?

And we cannot do that. We cannot address the problems that I've told you about if we cannot develop a mutual understanding with our patients. We cannot do it with this kind of numbers.

And how do we address this problem? This is what I place before you, Senator. In light of these problems, I feel that the Council of Navajo Physicians have taken attitude toward addressing some of the chronic medical problems, the recurring health problems that we have on the reservation.

We're a group of physicians that number about 14. We have all been trained as physicians, we have graduated from university medical schools, we are boarded in our medical specialties, and we have created the council called the Navajo Council of Physicians.

And to address some of the medical problems, we have begun to work with the tribe, the IHS, and we'll be happy to assist your committee, and maybe addressing some of these problems for you, placing some recommendations, and we'll be happy to work with you.

In closing, I'd like to thank you, Senator Bingaman, members of the committee, in allowing us to participate in this committee hearing.

Thank you.

Senator BINGAMAN. Thank you very much, Doctor. I appreciate your being here.

[Dr. Begay's prepared statement, on behalf of the Council of Navajo Physicians, follows:]

PREPARED STATEMENT OF DR. RAY BEGAY, CHAIRMAN, NAVAJO COUNCIL OF PHYSICIANS

Mr. Chairman and members of the committee: Thank you for allowing us to participate in the committee hearings for the testimony regarding Senate bill 400. Speaking on behalf of the Council of Navajo Physicians, I am delighted to participate in the hearings today and congratulate Senator Bingaman for his efforts in bringing about this Senate Bill.

One of the areas the Council of Navajo Physicians has been concerned about is health care trends for the future. In my opinion, this bill is only a start in addressing some of the greatest health problems that will face us in the future. According to our statistics and those compiled from the Navajo Tribe, we feel that our current mortality and morbidity rates from accidents, childhood diseases and those of early infancy, infectious diseases, and the increasing incidents of cardiovascular disease, cancer, and other industrially related disease, alcoholism, motor vehicle accident, nutritional disorders and attendant medical problems, depression, anxiety, and other mental health needs will face the Indian Health Care as one of the leading causes of mortality and morbidity on the Reservation.

Despite the current initiative to control some of these medical problems we have not made progress equivalent to reducing some of these health problems comparable to the rest of the United States.

In the past, health care needs on the reservation have primarily been addressed to only the acute illness, however due to emergence of new problems on the reservation, we feel programs directed towards the prevention and recurrence of these disease processes need to be instituted. The approach to medical illness in the Navajo culture has always been met with a lot of mysticism. In reality disease processes are so much like treatment processes in modern and traditional medicine with some similarities and some differences. Medical illness, before it could be adequately treated by the patient and physician, the patient and the physician have to understand some of the disease processes and their relationship to the patient, the environment, the surroundings, and some of the dynamic processes which originate in the medical illness. When the reality of certain disease processes become evident to the patient and the physician, they can then address the proper treatment for a given illness. Like all disease processes there are certain recommendations as far as recurrences and prevention of certain disease processes which are always given to the patient. This concept appears to be emerging in the Senate bill 400 and we are delighted to see this bill is addressing some of the recurrences of some of the most common health problems that we have on the reservation.

We all feel medical illnesses are in a dynamic equilibrium between the socio-economic needs, various cultures, various political atmosphere in our current society.

Despite all of the above problems, we feel that taking a route in preventative medical illness, addressing some of the main reasons for the recurrences of the common and recurrent illnesses, is only a step towards providing good health care for the people on the reservation.

On behalf of the Council of Navajo Physicians, we endorse this bill in its entirety with a few additions. We feel there should be a provision for adequate funding for training of new physicians, health personnel, and other professionals who would implement these programs.

We find that the ratios of physicians to the population on the reservation are still far below the national levels and feel that to promote health care and disease prevention we need an adequate number of professionals to address these problems.

We thank the chairman, Senate committee members for allowing us to participate in the hearings for the Senate bill 400.

Senator BINGAMAN. Let me just close by once again thanking everybody who has participated. Once again thanking my staff and Senator DeConcini's staff, and the staff on the Select Committee on Indian Affairs for their work in putting this hearing together.

Thanking Senator DeConcini for coming from Arizona to conduct the hearing and participate in it, and thanking Congressman Richardson also for his participation.

I think we've gotten a lot of good testimony. I hope that we can use the testimony to improve the legislation that we're pushing through the Congress now, and I also hope we can use the testimony to identify some additional initiatives that we can pursue to improve the health of Indian people in this country.

That's the purpose of what we're all about, and I think your presence today is a sign that there are people interested in making progress on this difficult subject.

So thank you again.

[Whereupon the hearing was adjourned.]

APPENDIX

Additional Material Received for the Record

FORT PECK TRIBAL EXECUTIVE BOARD
P. O. Box 1027 Poplar, MT 59255
ASSINIBOINE & SIOUX TRIBES

1985 JUN 17 AM 11: 17

June 14, 1985

Honorable Mark Andrews
Chairman, Senate Select Committee
on Indian Affairs
United States Senate
Washington, D.C. 20510

Re: S. 400, a bill to provide health promotion and disease prevention services foı Indians (156.21)

Dear Senator Andrews:

Thank you for your invitation to submit testimony concerning S. 400, a bill to provide health promotion and disease prevention services to Indians. Please add the testimony of the Assiniboine and Sioux Tribes of the Fort Peck Reservation to the record of the hearing held before the Committee on June 1, 1985, in Gallup, New Mexico.

The Assiniboine and Sioux Tribes of the Fort Peck Reservation strongly support the objectives of S. 400. The bill would require the Indian Health Service (IHS) to undertake a well-planned and organized effort to provide health promotion and disease prevention services to Indians. IHS provides some services of this type now, but in an inconsistent, unfocused way. There are no statutory standards to guide IHS' efforts in this regard. As a result, many of the existing programs are ineffective, and many needed programs do not exist at all.

S. 400 would address these problems in two ways. First, it would provide standards for both the type of services to be provided and the necessary planning. Second, it would establish a strong statutory foundation for the

Community Health Representative (CHR) program. This is the IHS program best suited to providing many health promotion and disease prevention services, but the current Administration tries to eliminate it every year.

The Tribes support both components of the Act, but suggest several amendments, which we discuss in detail below. Briefly, the amendments are as follows:

1. Add "provision of physical therapy" and "improvement of water quality" to the definition of health promotion and disease prevention services in Section 3.

2. Require IHS to rely on tribal health plans in developing its plans for provision of health promotion and disease prevention services under Section 4 (draft amendment attached).

3. Require the demonstration projects authorized by Section 4 to focus on a limited number of areas, including reduction of alcohol and drug abuse (draft amendment attached).

4. Add "family planning" and pregnancy and infant care" to the list in Section 5 of health promotion and disease prevention services in which CHRs should receive training.

We also discuss the need for greater IHS appropriations if the objectives of S. 400 are to be accomplished.

Planning and provision of health promotion and disease prevention services (Section 2 - 4 of S. 400)

Section 3 of S. 400 lists the types of services that are included in the terms "health promotion" and "disease prevention." These services would address some of the most troublesome health problems on our Reservation, including alcohol and drug abuse, hypertension, and teenage pregnancies. Some of the services are designed to reduce factors that cause or aggravate serious illness, such as tobacco smoking, obesity and poor physical condition, stress, inadequate pre-and post-natal care, and poor nutrition. All of these are significant problems on our Reservation. In fact, we need services of every type listed.

We would, however, like to point out a basic problem in providing all of the services envisioned by the bill. It is of course desirable to list certain services and order IHS to provide them. However, if Congress does not appropriate additional funds, even the best intentioned bill will not help. Either IHS will simply not be able to provide all of the services, or it will be forced to shift funds from other important areas.

We have already seen this problem on our Reservation. For example, our tribal health program provides health education under contract with IHS. Since reduction of drug and alcohol abuse is one of our top priorities, we have assigned our health instructor to provide preventive education on drug and alcohol abuse in the local schools. However, in order to do this we have had to stop all instruction on physical fitness and certain other areas. If S. 400 is enacted but no additional funds are appropriated, we would be faced with other hard choices.

We know that the Senate Select Committee on Indian Affairs has consistently supported increased appropriations for IHS, as has Senator Bingaman, the sponsor of S.400. If S. 400 is enacted, we ask that the Committee seek appropriation of sufficient additional funds so that IHS will be able to carry out its new responsibilities in the area of health promotion and disease prevention without diverting funds from other important programs.

We would also like to suggest that Section 3 of S. 400 be amended to add two new types of services. The first is provision of physical therapy, which would be added under the "health promotion" heading. Many of our elderly Indians have chronic arthritis and other conditions which could be improved through regular provision of physical therapy. Physical therapy, which could be provided by CHRs, would raise these patients' condition to the best possible level, and would avoid the deterioration and complications that result from their lack of therapy. Also, physical therapy would be beneficial to many patients who have had accidents or surgery and need therapy to achieve a full recovery.

We also suggest that improvement of water quality be added to Section 3 of the bill under the "disease prevention" heading. The water quality on many parts of our Reservation is very poor. Many of our families have individual well systems. The water from these systems has a dangerously high level of chemicals, and in some areas solid waste and sewage has contaminated the water table. This terrible water is very unhealthy, and we need additional funds to combat the problem. Inclusion of this item in S. 400 would give us additional leverage with IHS to secure the needed funds.

Section 4 of the bill would amend the Indian Health Care Improvement Act to require IHS to develop a three-year plan and a ten-year plan for provision of health promotion and disease prevention services to Indians. The Fort Peck Tribes support the requirement of comprehensive plans. We are informed by IHS officials working in this area that the requirement will give IHS the incentive it needs to undertake a vigorous, well-organized effort to provide health promotion and disease prevention services.

Section 4 would also require Indian tribes to include plans for provision of health promotion and disease prevention services in the tribal health plans they are required to submit to IHS. Then, in the report to be submitted within a year of enactment of S. 400, the Secretary of HHS would have to include the plans that IHS had developed, as well as a summary of the tribal plans.

As noted, we support the requirement that IHS develop short- and long-term plans, and also the requirement that tribes develop their own plans as part of the tribal health planning process. However, the bill should be amended to clarify the relationship between the overall IHS plans and the tribal plans. The tribal planning process, originally mandated by the Indian Health Care Improvement Act, has been a great step forward in ensuring that the individual health needs of each tribe are met. The portion of the tribal health plans dealing with provision of health promotion and disease prevention services would be by far the most valuable source of information for IHS in preparing its own plans for provision of such services. Yet, the bill would not even require IHS to take the tribal plans into account in developing its overall plans. We suggest that S. 400 be amended to require IHS, to the greatest extent possible, to base its own short- and long-term plans on the tribal plans. A draft amendment is attached.

Section 4 of the bill would also require the Secretary of HHS to establish between 1 and 4 demonstration projects to determine the most effective and cost-efficient means of preventing disease and promoting health among Indians, to train Indians to provide health promotion and disease prevention services to members of their tribes, and to train IHS personnel to provide such services. The bill would authorize $500,000 for the demonstration projects.

While we support the proposed demonstration projects in principle, we believe that their objectives are so broad that they will scarcely be able to scratch the surface in accomplishing any single objective. We suggest that this section be amended to require the projects to focus on a limited number of areas in the field of health promotion and disease prevention. These areas should be those identified by IHS as the most important after consultation with tribes. We suggest reduction of drug and alcohol abuse as one of the areas that should be included in the demonstration projects. A draft amendment is attached.

Community Health Representatives (Section 5 of S. 400)

Section 5 of S. 400 would provide a statutory foundation for the CHR program. We support Section 5, as it will make the CHR program less vulnerable to attempts to reduce or eliminate its funding, and will also provide standards to guide the program.

Section 5 lists eight areas of health promotion and disease prevention in which CHR's should receive training. We suggest addition of two very important areas - family planning and pregnancy and infant care. These are high priority areas for the Fort Peck Tribes, particularly in light of the distressingly high number of teenage pregnancies on our Reservation. Many of these young mothers have been rejected by their own families, and have no way to care for their children once they arrive. These problems can have very serious consequences for the health of both mother and child.

Given the proper training, CHRs could be of great assistance with these problems. They could provide instruction in appropriate measures of birth control, encourage the young mothers to obtain appropriate prenatal care and assist in providing such care, and provide followup services to both mother and baby once the baby is born. The family planning aspect is particularly important on our Reservation, as neither IHS nor the local schools are currently providing any instruction in this area.

Thank you very much for your consideration of our testimony. We would be happy to provide further information on any of the points we have raised.

Respectfully submitted,

Norman Hollow

Norman Hollow, Chairman
Assiniboine and Sioux Tribes of
the Fort Peck Reservation

Enclosures

Copy to: Honorable Jeff Bingaman

OMAHA TRIBE OF NEBRASKA

P O Box 368
Macy, Nebraska 68039

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1985 MAY 23 PM 1: 15

May 17, 1985

Mark Andrews, Chairman
Senate Select Committee on Indian Affairs
United States Senate
Washington, D.C. 20510

Dear Senator Andrews:

The Omaha Tribe of Nebraska is supporting Senate Bill 400 cited as the "Indian Health Promotion and Disease Prevention Act of 1985." It is the contention of this Tribe that the major diseases affecting its tribal members is that of Diabetes and Alcoholism and Drug Abuse. That the long range plan for health improvement is in the areas of prevention, disease control, and health promotion.

On the devastation of the preventable disease diabetes; a noted associated press reporter headlines1/: "Diabetes epidemic afflicts American Indian...." "It crept up almost by stealth until now. Among some Indian Tribes, diabetes is a full-fledged epidemic, afflicting more then half the population on certain reservations. Early medical misconceptions, cultural disparities, and inertia all contributed to a grim situation that has not yet run its course...." The incidence of diabetes among the Omaha is from 35-60% for adult members. The average white American has one chance in 20 to develop diabetes; an American Indian has one chance in 4.

Dr. Theodore Redding, Chief Medical Officer, I.H.S., Phoenix, is quoted in the same Journal article by Krohholm2/. "If something's going to be done, it must be done early; If the emphasis continues to be just monitoring blood sugar and increasing insulin dosages, cutting off peoples legs and putting people on dialysis, there will never be any improvement...."

A good physician will not only treat symptoms, but look for causes, Diabetes is a cause of many of out illnesses. Renal failure, blindness caused by retinopathy, circulatory and nerve deterioration causing gangerine and amputations, high blood pressure, strokes and heart attacks can be directly attributed to diabetes.

1/ Associated Press Writer William Krohholm, Sioux City Journal, Sunday, May 5, 1985.

2/ Ibid

The form of diabetes which American Indians are subject to is preventable, as is the disease of alcoholism. Yet, at a time when these diseases are rampant among the tribe, Indian Health Service has literally cut out Health Education positions and relagated this function to a rear burner. The Omaha Tribe has a 0.5 position due to earlier I.H.S. budget cuts. Socio-economic factors play a major role in the Health status of our Tribe. Health promotion is essential.

Efforts to obtain Federal Block Grant funds from the State of Nebraska to off-set the gap for health services needed has met with no success.

The Infant Mortality rate among the Omaha during the first two months of 1985 indicate a death rate nearly four times greater than the National average. Over 50% of the prenatal group is high risk. The incidence of Sudden Infant Death (SIDS) has been identified as being greater in the Indian population than within the rest of the Nation. This has been true of the Omaha Reservation. Within the past year, three infants have been on apnea monitors after evaluation as siblings of previous SIDS children. Another infant is also on the monitor as a result of respiratory arrest. If SIDS is related to maternal risks and complications as indicated by some authorities, the potential for more SIDS within the population is very great.

Handicapping conditions are also prevalent among the children of the Omaha Reservation. Approximately 150 of the 400 students enrolled in K-12 Macy Public School receive services from the Special Education Program on a partial or all day basis. Currently 13 children are in the Early Childhood Classroom (birth to 5-year olds). In addition there are 35 all day students in other Special Education Classrooms. Sixty-five students are served by the Speech pathologist which corresponds to the high incidence of Otitis Media in younger children.

Otitis Media is our most prevalent illness noted in the newborn. Average age for an infant first diagnosis of otitis media is approximately three months of age, with some as early as one month of age.
Approximately 90% of the Infant population will be seen at the Carl T. Curtis Health Education Center with at least one episode of otitis media during the first year of life. Approximately 40% will be seen at the clinic five or more times during the first year of otitis media.

The recent increases in infant mortality on the Omaha Reservation is alarming, maternal factors as well as illness in the infant contribute to this increase. The same factors contribute to the high incidence of handicapping conditions within the children.

Community Health Representatives play important roles in assisting the health service providers in our community. Home visits and patient monitoring have helped to keep mobidity and mortality rates down. In spite of this, their services are even more in demand. Each year opponents of the C.H.R. program have deleted this vital program from the budget. There is no substitute for their services.

S 400 is a vehicle which will mandate the coordinated efforts of Federal, State and local and Tribal agencies.
S 400 specifically notes that: "...in addition to the provision of primary health care, the Indian Health Service should provide health promotion and

disease prevention services to Indians..."

The Omaha Tribe expresses further that; Senate Bill 400 is an excellant companion Bill to S 277, and request that adequate funds be appropriated to carry out the intent of S 400.

Sincerely,

Wallace Wade Miller

Wallace Wade Miller, Chairman
OMAHA TRIBE OF NEBRASKA

CC: Nebraska Congressional Offices
Washington, D.C.

WWM:edl

(505) 455-2273

J. GILBERT SANCHEZ
GOVERNOR

GARY S. ROYBAL
1ST LT. GOVERNOR

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PERRY MARTINEZ
JOSE V. AGUILAR, SR
JUAN TAFOYA

May 29, 1985

Honorable Senator Dennis DeConcini
Senate Hart 328
Washington, D. C. 20510

Senator DeConcini:

I regret that I cannot attend the Hearing because of other commitments.

I would have liked to deliver the speech in person. However, I strongly urge our Congressional Delegation to support Senate Bill 400.

Sincerely,

for Gary S. Roybal
J. Gilbert Sanchez
Governor

JGS:mrb

Enclosure (1)

PUEBLO DE SAN ILDEFONSO ROUTE 5 BOX 315-A SANTA FE, NEW MEXICO 87501

(505) 455-2273

J. GILBERT SANCHEZ
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JOE F. SANCHEZ
PERRY MARTINEZ
JOSE V. AGUILAR, SR.
JUAN TAFOYA

GREETINGS!

HONORABLE SENATOR DE CONCINI

HONORABLE SENATOR BINGAMAN

DISTINGUISHED COMMITTEE MEMBERS

My name is J. Gilbert Sanchez. I am Governor of San Ildefonso Pueblo and on behalf of the People and Tribal Council, I am pleased and honored to speak before you today.

I have come here to address the State of Health Services and the importance of Senate Bill 400 - THE INDIAN HEALTH PROMOTION AND DISEASE PREVENTION ACT OF 1985. Therefore, I support and strongly urge the Senate and House of Representatives to pass the Act and provide sufficient authorization for its successful implementation.

However, there are some points we wish to emphasize:

(1) The establishment of a National Health Promotion Policy within IHS is essential - however, if no health promotion exists then under what policy and for what purpose has IHS been operating? The Tribes want IHS to be responsive to our needs. If a policy is to be established then let the Tribes establish the policy and let the policy mandate IHS to meet our needs rather than the Tribes hoping our needs fits the IHS policy and priorities for funding.

(2) The National Health Promotion Policy will require IHS to develop a long term plan of tribal and national health objectives. This is well and good however, if you remember some five (5) years ago the Tribes wrote a comprehensive Tribal Specific Health Plan; in which the Plan was never implemented nor was it ever used by the Tribes as a guide for improving health conditions on the reservation. The reason why the Plan was never used is because the Congress of the United States never authorized the funds necessary to implement the Plans, goals and objectives.

PUEBLO DE SAN ILDEFONSO ROUTE 5 BOX 315-A SANTA FE, NEW MEXICO 87501

Also, if new goals and objectives were established would there be enough monies authorized to fulfill the long range goals and objectives?

(3) We totally and absolutely support the improvements to the continuation of the Community Health Representative Program. The Tribes rely on this Program whole-heartedly for the majority of healh services delivery on the reservation. Therefore, we not only support this feature of the Senate Bill 400, but we also recommend that the CHR Program be priority number one for any long range goals.

(4) We support the concept of projects which call for the implementation of health promotion and disease prevention projects at the community level. We question the word "DEMONSTRATION." We believe the Projects should be established using current documents and data to justify the Project and thus allow the Tribes to implement them immediately.

(5) We agree with the definitions of health promotion and disease preventions as described in the Act. We feel that too little attention has been offered to the preventative side of health care. We believe that prevention must focus on physical fitness, teenage drug and alcohol abuse, nutrition, stress, immunization and many others. However, we do not support the idea of grouping all the preventative needs into one big category. We believe that prevention should be specifically targeted to specific health needs. For example: Physical fitness should be funded separately and should be designed to encourage the individual to participate in fitness programs by establishing programs through the CHRs on the reservation.

(6) Lastly, we encourage the IHS to eliminate the redtape and unnecessary problems of contracting and recontracting CHR programs. Each year the Tribes go through many hours of typing, writing and planning for the same basic activities. This is not a fault of the Tribes but a fault of the Congress and the President for not adequately funding the IHS. We do with our funds the best we can, we can't do all we want because there is not enough monies. Therefore, to establish an elaborate proposal process, review process and award processs is a waste of time, energy and money when the Program is going to do the same thing it always has.

In closing, I appreciate the opportunity to speak before you. I appreciate your time, attention and concern. And, we as people of San Ildefonso Pueblo applaud Mr. Bingaman for his efforts in Senate Bill 400. We acknowledge Mr. DeConcini for his concern for Indian Health. We totally and absolutely support Senate Bill 400 and encourage the Congress and the President to make this Act a reality.

Thank you.

PUEBLO OF ZUNI
P. O. BOX 339
ZUNI, NEW MEXICO 87327

CHAUNCEY SIMPLICIO
Governor
SEFFERINO ERIACHO, SR
Lt Governor
ROGER TSABETSAYE
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HARRY CHIMONI
Councilman

RITA ENOTE LORENZO
Councilwoman
LOWELL PANTEAH
Councilman
CHARLES HUSTITO
Councilman
KEN WATO

In reply refer to:

May 31,1985

Chairman, Mark Andrews
Senate Select Committee on Indian Affairs
838 Hart Office Building
Washington, D.C. 20510

Dear Honorable Chairman Andrews:

The Pueblo of Zuni Community Health Representative (CHR) Program hereby submits written testimony in support of S.400 Indian Health Promotion and Disease Prevention among American Indians. We are in full support of the amendments to the Indian Health Care Bill which is designed to make health promotion and disease prevention a priority within IHS. In addition, we also strongly support Senator Bingamin's legislation which has provisions to upgrade and improve the Community Helath Representative (CHR) Program as a main vehicle for disease prevention services.

The Pueblo of Zuni - Community Health Representative (CHR) Program at present has been very productive and effective in the Zuni Community with initiating acute awareness of health promotion and disease prevention. Zuni CHR Programs goal is to actively involve the Zuni population in the maintenance and upkeep of their own health. Likewise, coordinating all our efforts into keeping our people out of the hospitals and in this way aid IHS in the reduction of medical expenses of Indians. CHRs, being the unique health resource they are have implemented ways to provide health care, promotion and disease prevention to members of the Zuni Tribe in a way which is consistant with our Zuni traditional health care practices and cultural values in conjunction with utilization of local medicine men.

Zuni CHRs are very instrumental in providing instruction and implementation of practical experience in health promotion and disease prevention particularly in areas of:

I. NUTRITION: For diabetics, dialysis, infants, mothers-to-be, elderly, failure to trive, obese and hypertensive patients/clients.

II. PHYSICAL FITNESS: Health promotion in this area is a high priority due to the high incidence of Diabetes concerning the Zuni population. Instruction and provision of physical fitness programs in this area is provided for handicapped clients of the Zuni community which includes amputees in wheelchairs, paraplegics, quadreplegics, elderlies, and includes health promotion in the work place involving tribal employees with successful results of weight loss and control of diabetes through diet and excercise without further use of medication. Thus, again aiding in the efforts to reduce medical expenses of Indians. Another important area is that the Zuni CHR Program staff along with Zuni tribal employees are setting the example by practicing what they preach by actively participating in physical fitness programs at the workplace which is strongly supported by the Zuni Governor and Tribal Council by allowing employees (1) hour of administrative leave (3) times a week for participation.

III. WEIGHT CONTROL: Again, CHR Program conducts a Zuni Tribal Employees Weight Control Program which also is open and encouraged for community members. This is in conjunction with the Zuni PHS/IHS Health Educator, Mr. Bruce Leonard. There is a total of (44) participants with the program which started on March 18, 1985 and will end on August 5, 1985 a total of 20 weeks. The goal of the program is for each participant to lose ½ a pound a week at the completion of 20 weeks each person should lose 10 pounds. At present there has been a total of 253½ lbs of loss divided by (44) participants averaging 5 3/4 loss per person. This would not have been possible without the CHR Program.

IV. CONTROL OF ALCOHOL ABUSE: CHRs are also very instrumental in this area with monitoring and counseling prenatal and new mothers on Fetal Alcohol Syndrome (FAS). CHRs have attended workshops in FAS and include this topic in other areas of maternal child health activities.

V. CONTROL OF HIGH BLOOD PRESSURE: Health promotion in this area is being carried out through efforts of nutrition counseling and implementation of physical fitness and excercise programs where blood pressure is monitored on a 4 week period basis with referrals to Zuni Service Unit as required.

Zuni CHR Programs priority II deals with "disease prevention". Areas of concentration and effort in this priority include:

A. Immunizations of infants and children in the home and schools with direct Licensed Practical Nursing services within the CHR Program which is very advantageous and in essence enhances the Zuni CHR Program.

B. Prevention/Control of Diabetes thru physical fitness/excercise. CHRs also perform and monitor blood glucose levels for community members.

C. Pregnancy/infant care which includes instruction on prevention of fetal alcohol syndrome (FAS). CHRs are in constant contact with prenatals and new mothers on a daily basis.

D. Accident prevention is carried out by a CHR/Tribal Safety Officer who conducts a Zuni Home Injury Prevention Program whose goal is to prevent death and disability in the Zuni community.

These are only a few of the highlights on the many acitivities and functions of the Zuni CHR Program which is aimed and addressed to raising the health status of Indians.

In conclusion, for the record, the Zuni CHR Program has been actively visible and constructive in the Zuni community. Most importantly, the services CHRs provide in health care areas often times zero in on sectors of the Zuni population that would otherwise remain neglected i.e., homebounders, elderly, handicapped, the disabled, infants, and teenage mothers-to-be. In addition, they also transport dialysis clients (90) roundtrip for hemodialysis treatment. There is absolutely no other resource available for this on-going life-saving service. In rural areas such as Zuni, many times barriers such as transportation, lack of a telephone, or failure to keep an appointment, prevent the treatment of serious illnesses or preventive care. As basic as these problems may appear, due to the fact that health services are not aggresively sought by a portion of the Zuni population contribute to the regression in health of the total population.

This is where the CHR is a vital link with informing the client how important it is to keep an appointment or likewise, teaching the client how to take charge of their own health through more frequent and improved health educational presentations and out reach home visitation. CHRs thus, reinforce and provide follow-through of health care initiated at the Zuni IHS/PHS Hospital and in essence are an integral and vital backbone of the health care team.

Achievement progress this past year involving the Pueblo of Zuni CHR Program has been Emergency Medical Services for the Zuni community on a 24 hour 7 day a week basis being provided without major patient related incidences. In addition the CHR/Optometry component provides patient and community education on various aspects of eye care. One-to-one patient education and numerous community programs (include puppet shows, movies, demonstrations,etc) have been presented to schools on such topics as refractive error, spectacle compliance and specticle repair. CHR/Optometry has also been involved as a role model for young people in the community. We have demonstrated to high school students and has been visible at community events and also sponsored physical fitness events in health promotion such as 5 kilometer Bike Races and Fun Runds. Other areas of progress includes the Commitment to open a dialysis unit in Zuni by September 1, 1985, expansion and awareness of the infant safety seat program an excellent accident study for 0-5 year old children which is being collaborated on with the State Accident Prevention Program. Some of these new programs being administered by the Zuni CHR Program are drawing non-IHS funds into the community, thus, stretching IHS dollars in a very tangible way.

Furthermore, Honorable Chairman, we are requesting your support in strongly recommending continuation of the Zuni CHR Program with an increase in the fiscal allocation in order that these vital functions and services will continue to serve and improve the health status of the Zuni community.

Your earnest participation and consideration towards this request will be greatly appreciated.

With Warm Regards

Antoinette Fontenelle
LPN/CHR Coordinator

cc: Jeff Bingamen

P. O. BOX 339
ZUNI, NEW MEXICO 87327

Governor
Lt Governor
Hd Councilman
Councilman

Councilwoman
Councilman
Councilman

In reply refer to:

STATEMENT
OF
RITA ENOTE LORENZO
COUNCILWOMAN, PUEBLO OF ZUNI

PRESENTED TO
THE SENATE SELECT COMMITTEE
ON INDIAN AFFAIRS
SENATE BILL 400 HEALTH PROMOTION
AND
DISEASE CONTROL
AMONG AMERICAN INDIANS

PRESENTED BY
RITA ENOTE LORENZO
COUNCILWOMAN
ZUNI TRIBAL COUNCIL
ZUNI, NEW MEXICO

JUNE 1, 1985

PUEBLO OF ZUNI
P. O. BOX 339
ZUNI, NEW MEXICO 87327

CHAUNCEY SIMPLICIO
Governor
SEFFERINO ERIACHO, SR.
Lt Governor
ROGER TSABETSAYE
Hd Councilman
HARRY CHIMONI
Councilman

RITA ENOTE LORENZO
Councilwoman
LOWELL PANTEAH
Councilman
CHARLES HUSTITO
Councilman
KEN WATO

In reply refer to:

May 31, 1985

STATEMENT
OF
RITA ENOTE LORENZO
PUEBLO OF ZUNI
TO
THE SENATE SELECT COMMITTEE
ON INDIAN AFFAIRS
HEARINGS ON SENATE BILL 400
HEALTH PROMOTION AND DISEASE CONTROL
AMONG AMERICAN INDIANS

Mr. Chairman and Members of the Committee:

My name is Rita Enote Lorenzo, Councilwoman from the Pueblo of Zuni, New Mexico.

I am happy to be here this morning representing my Tribe. The Zuni Tribal Council are in favor of supporting the Senate Bill 400. We want to thank Senator Jeff Bingaham for introducing this bill.

Our health needs are tremendous, but working together we can conquer some of the areas in need.

I am submitting the Zuni Tribal statements on our needs for the record.

Thank you.

P. O. BOX 339
ZUNI, NEW MEXICO 87327

GREAT SEAL OF THE ZUNI TRIBE

Governor
Lt Governor
Hd Councilman
Councilman

Councilwoman
Councilman
Councilman

In reply refer to:

OUR PHILOSOPHY WITH REGARD TO "GOOD HEALTH"

Kop leya' a:na'dun dekkwin hon eluday a:dek'yanna? "How shall we from now on live pleasantly?" For many generations the Zuni people have been asking this questions, and seeking ways to achieve that goal as a lifestyle for themselves and their families. It is a question which incorporates not only how Zunis conceptualize the world around them, but also their views as to just what constitutes "good health." If we are to live pleasantly, obviously our people must be health and happy. This, according to our old ones, can be achieved through a profound respect for all living things and for the creation around us. To live in harmony with each other and with nature are basic essentials to "good health." In former generations our men maintained good physical condition through rigorous work in the fields, running "stick races," and active participation in the ritual dances. Today, many of our men live a somewhat sedentary life, relying on automobile transportation, and finding their own functional roles in our society being diminished. It is a proven fact that wrong attitudes toward life, and wrong use of the elements of nature, bring about poor physical and mental health. We are seeing some of these wrong attitudes at work in our community as many Zunis of the newer generations seem to be living only for the moment, showing concern only for the symtoms of ill health and for the specific ailments themselves; not focusing their thoughts on the causes of disease, or methods of prevention, or consequences of ill health. In order to reverse this trend, we feel that it is essential for us to re-direct the attention of our people to respect for life and creation, and to re-emphasize preventive living and attitudes. This can be done through greatly improved efforts in the field of health education. We believe the area of health education to be our greatest need because of its potential impact on the over-all health status of our people.

Our concept of "ill health" certainly includes the effects of physical disorders and mental stress. However, health problems most feared by our people are those which seem to lead most certainly and directly to death (ie. terminal cancer, heart trouble). There is a more subtle threat to the life and health to the life and health of our people in the apparent fatalistic attitude many have toward the problems of alcoholism. While it is well-documented that alcoholism is a major contributing factor to poor health and mortality among our people, and while many are willing to acknowledge that alcohol abuse is a serious problem here, there is a certain futility which leads to a surface indifference expressed by many in reference to people with drinking problems: "well, that's just the way he is"--a common expression among our people.

What can be done about this? Again health education is necessary--but it must involve a concerted effort aimed at the younger generation so as to prevent (or at least minimize the potential for) the development of substances abuse as a pattern in their living.

If we can manage to revive former regard for living things, and emphasize the prevention and cure of those conditions which lead to death, disease, personal crises and social crises then we shall be able to say: "In this way we shall live pleasantly."

P. O. BOX 339
ZUNI, NEW MEXICO 87327

GREAT SEAL OF THE ZUNI TRIBE

Governor
Lt. Governor
Hd. Councilman
Councilman

Councilwoman
Councilman
Councilman

In reply refer to:

OUR PEOPLE

The Zuni Indians have occupied their present land for many centuries. Down through the years we have struggled against cold winters, and sought to live in harmony with a dry and forbidding land. We have planted our corn and tended our livestock with the confidence that our faith and prayers would bring the life-giving rain and ensure the general good health and prosperity of our people. Our religion prevades virtually every phase of our living. Our lives are ordered by its tenets and conscientious practice. Almost without exception, our people adhere tenaciously to the prayers and ceremonial observances of our ancestors.

Our social and linguistic structures, also remain very much intact despite many conflicting influences from the outside. We live in a closeknit society, concentrated in a small geographic area of northwestern New Mexico, seeking the mutual good of our people. Our culture is both matriarchal and matrilocal. In may of our homes, even yet, the grandmother has as much responsibility and say-so in the care of small children as the younger mother. This is particularly true in the case of many teenaged mothers who return in school, leaving the child in the care of grandmother. Even the casual observer can see that the Zuni people retain a strong a virile culture, at times in conflict with some aspects of non-Indian society.

Being a Pueblo society, Zuni s a somewhat genetically distinct group. These factors create special medical problems including diabetes mellitus, hypertension, abesity, and alcohol and drug abuse. The Zuni people also have important traditional methods for dealing with health-related problems. In a recent survey, 50.1% of those polled indicated they would refer their family to the medicine man for medical attention, and 26.7% indicated that they had personally visited they medicine man within the previous six months.

A major factor which has helped us to maintain our own cultural identity despite centuries of contact with outsiders is the tenacious way in which we have kept and utilized our own language. We continue to use our language in virtually every pahse of our living (including ceremonial, political, social, casual, and formal situations). Rather than borrowing works for concepts which are new to our people, most often we coin new descriptive terms from within our own native vocabulary. This is also true of the versatility of our language in reference to health conditions. By far, the overwhelming majority of our people still use their own mother tongue in preference to English, though many are functionally bilingual in most circumstances. It is very important to note, however, that more interpretation from English to Zuni and Zuni to English is needed in the field of medicine than in most other experiential categories. Indeed, our language is very much alive, and serves as reservior for our oral history, culture and treasured thoughts.

Through generations, our people have become a mutually interdependent cohesive unit, and thus have learned the many advantages of a collective cooperative spirit. Therefore, we are determined to work closely with those who are providing health care and services for our people, and to communicate openly with them regarding the factors other than statistical data for establishing criteria and for assessing the actual needs of our people.

OUR PROBLEMS

The following problems were brought to light in a combined meeting between Indian Health Services and Tribal Council. While the opinions expressed do not necessarily reflect the views of major segments of the community, the fact that they are preceived as problems by Tribal Council.

The health conditions which are foremost in the minds of our people as major health problems are:

a. Alcoholism and its effects (ie., accidents, suicide, violence, family trauma)

b. Diabetes

c. End Stage Renal Disease

d. Handicapped Children

e. Adolescent Health

P. O. BOX 339
ZUNI, NEW MEXICO 87327

CHAUNCEY SIMPLICIO
Governor
SEFFERINO [illegible], JR.
Lt. Governor
ROGER TSABETSAYE
Hd. Councilman

HARRY CHIMONI
Councilman
[illegible]
Councilwoman
LOWELL PANTEAH
Councilman
CHARLES HUSTITO
Councilman

May 30, 1985

Dear Sirs:

At the National Tribal Chairmen's Association (NTCA) meeting in Albuquerque last March, a resolution was passed declaring alcoholism and substance abuse to be the leading health and social problem on reservations throughout the United States.

And yet the Indian Health Service, charged with meeting the health needs of Indian people, does not treat alcoholism as a primary disease. They treat physical problems secondary to alcohol abuse, and may give counseling to alcoholics while they are hospitalized, but for intensive inpatient treatment of alcoholism as a primary disease, we have to send our clients to state supported alcoholism treatment facilities. These facilities are often overcrowded, with long waiting lists, and vary greatly in their effectiveness.

This approach to alcoholism seems to reflect the historic view of alcoholism as a legal, moral or psychological issue, and is not in keeping with the scientific advances that have been made in this field in recent years.

Tribal outpatient programs under contract with IHS can do much in treating the alcoholic who does not require intensive care, or who is highly motivated for treatment. But for many, if not most, comprehensive inpatient treatment is essential to properly start the alcoholic on the long road to recovery.

I would therefore urge the Congress and Indian Health Service to consider two alternatives: 1) that regional IHS alcoholism treatment centers be established employing the latest knowledge of addictionologists and treatment specialists, or 2) contract health care funds be made available on a priority basis for inpatient treatment at facilities in the private sector.

In addition, I would urge the powers that be to start treating the families of alcoholics as primary clients. Research is showing that families adjust to alcoholism in a pathological way, and that that maladjustment persists long after the alcoholic stops drinking. Often that pathology leads to relapse if it is not treated, and it can be treated. The family can be started on their road to recovery oftentimes even if the alcoholic is not in treatment and does not stop drinking.

However, at present, the Alcohol Treatment Guidance System (ATGS) forms that IHS requires us to use are not designed to allow us to receive credit for treatment of families if the alcoholic is not also in treatment. I would like to see the forms changed so as to accommodate treatment of the family as the primary client.

In summary, in spite of the NTCA acknowledgement of alcoholism as the leading health and social problem facing the American Indian today, and in spite of the fact that medical science is affirming that alcoholism is a primary disease, and not the symptoms of another mental disorder, the efforts at treatment have been piecemeal and have not incorporated the latest knowledge available in the treatment field. I therefore urge that consideration be given to the above items, and that alcoholism treatment be given the priority which is called for in the NTCA resolution.

Thank you.
Respectfully submitted by:
Wayne F. Vanderford
Wayne F. Vanderford
Director, Zuni Community Services

HANDICAPPED CHILDREN

There are approximately 190 Zuni children born/year or about 1,000 Zuni children between birth and six years of age. Many of these children are at high risk for birth defects (i.e., from maternal diabetes or alcohol abuse), developmental delays from poor parenting and accidents. Because of the bilingual nature of the homes, many children have speech and language delays. Otitis media and meningitis are well known infectious diseases that are highly prevalent to Indian children and can cause serious hearing loss.

The National Center for Health Statistics estimates that 21% of young school age children have handicapping conditions such as those described above. Most school age handicapp begin before birth or in the infancy and pre-school years. Thus, there are approximately 200 children from 0-6 years of age who could be at risk for at least one of these conditions.

The Zuni Head Start Program provides services for four year olds and for an occasional three year old with demonstrated needs. However, there is not a special education teacher or speech therapist who works intensely with these children. Children from 0-3 years of age have even fewer services available. The Indian Children's Program visits Zuni for 3-4 hrs/month to provide mainly diagnostic evaluations and occasionally to prepare the individual educational assessment (IEP) required under P.L. 94-142, The Education for All Handicapped Children Act of 1975. The McKinley Area Services for the Handicapped has a worker who carries out the IEP in a home bound program. However, only 14 children from 0-3 years of age can be served, with no anticipated increase in funding or services.

A community based center for young handicapped children is desperately needed in Zuni. This facility could be coordinated and run with a day care for non-handicapped children. A permanent administrator, certified early child education specialist, speech therapist and aids would be needed Several elderly Zuni women have shown a strong interest to volunteer in such a center. Parenting skills would be taught for those parents showing a need. A center near the high school could allow teenage mothers to remain in school yet have their infants nearby. Such a center exemplifies primary prevention at its essence - the care of young children in need before their handicapp becomes disabling.

May 31, 1985

ADOLESCENT HEALTH

The adolescent population residing in the Pueblo of Zuni has unique health needs identified as:

1) Alcohol and substance abuse
2) Living in families that abuse alcohol
3) Depression and suicide
4) An unusually high tendency towards diabetes mellitus
5) Venereal disease
6) Behavioral problems
7) Need for career guidance

These problems often go unrecognized by the community and the hospital since teenagers practice crisis oriented medicine and will rarely attend to their medical problems in a prevention oriented manner. The PHS Hospital is located four miles from the village. An adolescent with a very personal problem often finds a confidential ride to the hospital difficult to obtain. There is much reluctance to be seen at the hospital for a sensitive problem if the adolescent knows he/she will see a friend or close relative working there. Thus patients wait as long as necessary before coming in for a visit. This can mean a serious emotional problem is ignored, routine school physicals not done, birth control not obtained, and prental visits begun late in pregnancy. At present, only 1/3 of young unmarried women in Zuni recieve their first prenatal visit during the first trimester. Thus, the approximately 30 Zuni teenagers who become pregnant each year do not utilize the exisitng prenatal services effectively.

The Zuni Teen Health Center identifies teen health care needs as its sole priority and staffs only individuals with a specific interest or expertise in adolescent health care. Utilization of services is improved due to an accessible, highly confidential, and empathetic service provided within walking distance to the adolescent. Utilization is also increased and the adolescent is safely exposed to the clinic by scheduling all the 6th and 11th grade school physicals at the teen center. Finally, a full range of psychological services are also provided in a completely confidential manner.

The current needs of the Zuni adolescent are insufficiently met by the Indian Health Service. For FY 1986 a total of $71,000 was requested from the Albuquerque Area/Indian Health Service Office for what was considered the minimal program necessary to address the unique adolescent problems seen in Zuni. However, only $25,000 was allocated the program. As a result the services of the mental health worker, secretarial support, and summer jobs program, and a needs assessment was not be supported by the Area Office.

As the Zuni Teen Health Center has become more accepted by the adolescents, the utilization of services has increased. We expect this trend to continue. In the next several years a larger, more comprehensive center should be funded and constructed, mental health and alcohol counselling provided, and direct medicalservices increased. Since primary prevention is most cost effective when delivered to a population at risk at a stage of illness before it becomes apparent, the need for solid financial support for the teen health promotion program is well justified.

May 31, 1985

END STAGE RENAL DISEASE

End Stage Renal Disease (ESRD) is a very common and serious problem for the Zuni people. The 20 Zuni patients currently on dialysis cost the federal government approximately $500,000/year. By 1982 the prevalence of ESRD in Zuni was 12 times the rate for whites in ESRD Network VI (Arizona and New Mexico) and four times the combined Indian rate for Network VI. The average annual incidence for Zunis in 1982 was 81 times that of the entire Network VI incidence.

Compared to other Indian groups such as the Pima, Papago, and Southern Colorado Utes in which diabetes accounts for up to 90% of the cases of ESRD, only 25% of ESRD in Zuni is due to diabetes. Thus, there is a large group of younger patients having renal failure as a result of glomerulonephritis and smaller, older group whose ESRD is caused by diabetes.

Since 1975 there have been an addition of two new cases/year to the prevalence of ESRD. By 1990 we predict a total of 30 patients will be on dialysis. Normally, a population the size of Zuni would only have two patients on dialysis. Furthermore, as the long term chronic complications of diabetes effects the population, the yearly incidence of ESRD may increase even further.

Renal failure raises an extreme hardship and trauma to these patients. Average total life expectancy after dialysis is required is only five years. Our patients must currently drive 80 miles a day, three days a week to receive their dialysis. They often spend the entire day at the dialysis center waiting for a ride home. They are usually exhausted and nauseated by the end of the day. All family members are in some way affected, by missing work to transport their relative, caring for them at home, or worrying about when their family member will die or when they themselves be afflicted by ~~the~~ disease.

Because of the large numbers of relatively young Zunis with ESRD due to glomerulonephritis, we are concerned about a possible environmental or genetic cause. No field studies have been done yet to investigate these possibilities. Several students from Stanford Medical School and UCLA Public Health School will spend two weeks here this summer to do a pilot cross sectional survey of patients with ESRD. This project is receiving no funding and the students are paying their own expenses. There is an urgent need to intensively investigate all possible causes of ESRD in Zuni by organized, well funded outside group so that preventive approach can be found to diminish the suffering from this disease.

May 31, 1985

STOCKBRIDGE - MUNSEE BAND OF MOHICAN INDIANS

STOCKBRIDGE - MUNSEE COMMUNITY
Route 1 Phone Bowler [illegible] 4111
BOWLER, WISCONSIN 54416

1985 JUN 12 PM 3: 54

June 10, 1985

Senator Mark Andrews
U.S. Senate Select Committee on
Indian Affairs
Washington, D.C. 20510

Dear Senator Andrews:

On behalf of the Stockbridge-Munsee Tribe of Mohican Indians of Bowler, Wisconsin, I am happy to make the following comments regarding Senate Bill S-400, Indian Health Promotion and Disease Prevention Act of 1985.

The 1978 Bemidji Area morbidity/mortality statistics give the four most leading causes of death as follows:

1. Diseases of the circulatory system
2. Accidents
3. Injuries
4. Neoplasms

Everyone of these causes is linked with lifestyle. Increasing amounts of evidence are supporting the belief that lifestyle changes can reduce the incidence and/or severity of these four causes. The Community Health Representatives on our reservation have played a very important role in health education in the area of health promotion/disease prevention. We feel it is vitally important that the role be preserved and enhanced.

We appreciate your office keeping in contact with our Tribe regarding this bill.

Sincerely,

Leon Miller

Leon Miller
Tribal Chairman

TESTIMONY PRESENTED TO THE INDIAN SENATE SELECT COMMITTEE

HONORABLE MARK ANDREWS, CHAIRMAN
ON JUNE 1, 1985

FOR

THE TRIBES OF NEVADA

Witness(s):

Alvin Moyle	Tribal Chairman Fallon Business Council
Alvin Moyle	Chairman of the Executive Board Inter-Tribal Council of Nevada

Mr. Chairman and Members of the Committee, my name is Alvin Moyle and I am the Chairman of the Fallon Business Council and Executive Board Chairman of the Inter-Tribal Council of Nevada.

I am here to testify on behalf of the 24 recognized tribes in the State of Nevada and to offer our support to the Indian Promotion and Disease Prevention Bill sponsored by Senator Bingaman.

The State of Nevada, geographically is the seventh largest state in the Union. The State spans from 320 miles from east to west and 490 miles from north to south. The miles of open space are punctuated by small, isolated communities far removed from the twenty-four hour glitter that is paramount in Las Vegas and the city of Reno. A state population base of just over 800,000 is divided unequally with 58 % in the southern tip around the city of Las Vegas and 24% in the northwest concentrated in the Reno and Lake Tahoe area. The remaining 18% is scattered across the other 95,000 miles, where the population averages 3 to 6.8 persons per square mile.

The current Indian population is approximately 15,225 of this an estimated 5,180 make up the urban Indian population.

The following is a breakdown by population of each tribal reservation or colony in Nevada.

	RESERVATION	TOTAL RESIDENT INDIAN POPULATION
-	Battle Mountain	314
-	Duck Valley	1,529
-	Duckwater	140
-	Elko	494
-	Ely	301
-	Fallon	730
-	Ft. McDermitt	678
-	Goshute	373
-	Las Vegas	118
-	Lovelock	192
-	Moapa	215
-	Pyramid Lake	364
-	Reno/Sparks	721
-	South Fork	134
-	Summit Lake	0
-	Walker River	643
-	Washoe: Carson Dresslerville	996
-	Wells	92
-	Winnemucca	100
-	Yerington	364
		8,498

The Indian Health Service, responsible for providing health services to Indians and Alaskan Natives had divided Nevada into two service unit areas, Schurz in the Western and Owyhee in the Eastern part of the State. Of the 24 tribes, 14 are located in the western half.

Only 5 areas are within a fifty mile radius of the two major urban centers of Las Vegas and Reno. The remaining nine areas are located in rural counties with populations even less sparce than the neighboring communities and with inadequate economic bases to attract, establish, and maintain permanent health care providers.

In the eastern part of the State ten (10) reservations and colonies share similar problems. Six of these areas are further than 30 miles from a health care facility or urban center.

The Indian Health Service maintains a 19 and 15 bed hospital to serve the Western and Eastern areas respectively. Both areas are additionally serviced by monthly or bi-monthly satellite field clinics. These clinics are designed to provide acute care, medical refills and intervention to patients who are isolated from medical providers. Limited medical care is provided at the hospital and although both hospital provide inpatient care, no surgical operation or procedure including deliveries are performed. These services are contracted out.

The availability of contract care is complicated because of the statewide maldistribution of medical manpower. The 1982 Physicians Registry indicates that of over 1200 physicians in Nevada, there are fewer than 75 serving the non-Indian population outside Las Vegas, Reno, Lake Tahoe, and Carson City. In contrast to the medical doctors available to the Schurz Service Unit population of 6,281 there are three (3) doctors at the Schurz medical facility.

In addition to this there is a high turnover rate for physicians located at the hospital. This causes disrupted field clinic schedules and general lack of continuity of care. This inconsistency leads clients to do without needed health care services, and increases the use of contract care providers. Use of contract care providers in turn leads to low utilization of health care because of communication problems between provider and client, the clients existing health care needs, follow-up and general inconsistency of the care received by the client.

All of these factors contribute to the deficiencies in health care provided to the Indian people. These deficiencies have resulted in the following:

1. The Native American infant mortality rate is 1.2 times greater than rates for all races in the United States.
2. The accident death rate for Indians aged fifteen to twenty four is 5 times greater than all races in the United States.
3. Accidents are the second leading cause of death for Nevada's Indian population.
4. Suicide rates for Native Americans between the ages of 25 to 34 are 3.3 times the national rate.
5. Indian alcoholism rates in the age group of 25 - 34 are 3.3 times the national levels.
6. Diabetes mellitus death rates for Indians is 2.6 times that of the United States population rate.
7. Indian's tuberculosis mortality rates is 5 times as high as all races in the United States.
8. Influenza and pneumonia mortality rates is 2.1 times that of all U.S. races.

These statistics were taken from "FY '82 Editions, Indian Health Service Chart Services Tables."

Among the leading causes of hospitalization in IHS facilities by disease category are:

1. Pregnancy, childbirth, puerperium
2. Accidents, violence, and poisoning
3. Respiratory system
4. Infective and parasitic
5. Mental disorders
6. Endocrine, nutritional and metabolic diseases
7. Circulatory system
8. Eye diseases

One sincere effort to deal with the inadequate care given, community isolation, economic restraints, traditional and cultural values and beliefs have been made through the Community Health Representative and In-Home Health Aid Programs.

In a ten month contract period from May 5, 1984 to February 2, 1985, the CHR's of 12 reservation communities transported patients 116,821 miles to health care providers. The transportation services are critical to small populations in economically depressed communities who are geographically isolated from medical providers.

In addition to providing an established vitally needed transportation service, it serves as the communication line between community members and health care providers. In much the same way, the In-Home Health Aids provide support care to the reservations elderly and disabled. Clients are evaluated and referred by a registered nurse who develops a care plan which the Aid follows in providing health services.

In situations where health care is inconsistent or inadequate, the CHR and In-Home Health Aid remains always available, always the source of information or the constant care provider. This is why it is important to upgrade, maintain, and continually develop the skills of these health care providers. These providers take patient's vitals, check medications, and monitor client's needs. They have been called upon to provide health education in the field with limited training in the areas they cover. Only recently in the state of Nevada have these providers been required to take the 40 hour First Responder course which provided instruction in on the scene emergency medical care. As was mentioned these people are in many instances, the only health care providers available for miles. With this training, emergency care on the reservation has become functional and accessible.

Even so, training in areas of preventative care such as otitis media, diabetes control, child immunization, recognition of therapeutic needs as well as individual rehabilitation therapy, and crises intervention are still very much needed in the remote, isolated areas these providers serve. Throughout the years the CHR and In-Home Health Aids have been in operation, training programs have been limited and those offered were costly and held in what were considered centrally located states. Unfortunately, training called for of 2 days to 5 weeks. Either way it caused a hardship on providers with families and tribes who could not afford training fees and a length of time away from the communities. Even those training sessions held in central locations in the state, were ineffective due to lack of time to expound on areas covered, or to get the hands on practice to see if the procedure was being done correctly.

The tribes of Nevada are very much in support of a means to provide our CHR's and In-Home Health Aids with the training needed to bring them up to the para-professional level. We cannot stress enough our need for such people in our communities due to our isolation, lack of medical provider and facilities, and our inability financially to bridge those gaps. For many years these providers have been identified as "taxi cab drivers" by those who have little knowledge of the lack of health care available on reservation communities. They are unaware of how these program staff play the role of emergency medical technicians, nursing personnel, environmental health technicians, health educators, etc.

These two programs provide vital services and we have no doubt that with the opportunity to be adequately trained, their current role in the communities will be even stronger.

WINNEBAGO TRIBE of NEBRASKA

WINNEBAGO TRIBAL COUNCIL P.O. BOX 687 WINNEBAGO, NEBRASKA 68071

1985 JUN 11 PM 2:33

June 6, 1985

Senator Mark Andrews
Chairman
United States Senate
Select Committee on Indian Affairs
Washington, D.C. 20510

Dear Chairman Andrews:

As Chairman of the Winnebago Tribe of Nebraska, I wish to support the promotion of Bill S. 400, Indian Health Promotion and Disease Prevention Act of 1985, introduced by New Mexico Senator Jeff Bingaman.

Winnebago is one of fifteen service units in the Indian Health Service Aberdeen Area. At present, our Tribal Health Department Component and it's component provide and utilize community based services and patient education as tools to implement many of the goals stated in the Bill S. 400.

We appeal to the Senate Select Committee on Indian Affairs to consider and support this bill. It is a vital means to ensure health care and promotion in the future to our Indian people across the United States.

Through our Health Department, we provide health education and promote health, through our Health Education Program, our Community Health Nursing Program; but, we cannot provide these services without the assistance of the Community Health Representatives. The Community Health Representatives Program is a vital link in achieving and maintaining this process of patient education through health promotion.

Our Community Health Representative Program is a main vehicle for patient education and monitoring. Early detections, education, and proper treatment are important issues in reducing incidences of diabetes and hypertension.

Our Community Health Representatives conduct monthly screenings for indications of hypertensive patients, diabetic patients, provisions of referrals, ambulance services, CPR classes, and Maternal Child Health follow-up, T.B. monitoring, and many other services not mentioned.

Health and Human Services Secretary, Margaret M. Heckler stated in a News Release, dated March 1985, that the infant death rate among American Indians and Alaskan Natives had dropped dramatically to the level of that of the whole U.S. population. In our community, our infant mortality rate is 61 per 1,000 live births; although our immunizations are 100% in the area.

We have one newly diagnosed diabetic per week. Winnebago has the highest alcohol/injury (29%) in the area.

The Aberdeen Area Indian Health Service is funded at a rate of $409.50 per capita for direct health care delivery services. The average American citizen spent $1,400 per capita for direct health delivery systems in 1984. It is our belief we are still in need of increased direct health care funding. However, through aggressive health promotion and disease preventive efforts, in the long run, this will improve our health care status and also decrease the need for astronomical appropriation levels for Indian health.

Our health statistics indicates we desperately need to maintain our health care delivery services as they are provided and will continue to provide. I wholeheartedly urge your favorable support of Bill S. 400 and appreciate your congressional efforts to make a significant impact on health promotion and disease prevention in the American Indian people.

Respectfully,

Reuben A. Snake Jr

Reuben A. Snake, Jr.
Tribal Chairman